Overview of Principles of Caring for Bipolar Patients

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Il faut aimer les alienés pour être digne et capable de les servier.” (“The psychiatrist must have special love for the severely mentally ill, in order to deserve and be capable of serving them.”).

Esquirol (1845)

25.1 INTRODUCTION

This overview chapter considers aspects of bipolar illness that have to do with its practical long-term clinical management on a day to day basis. In other words, we will cover what is generally considered the clinical art of how to care for these patients. This art, which obviously has to take into consideration the existing clinical science on bipolar disorder, nonetheless derives largely from the authors’ intimate hands-on experience with patients and their families. It is based on the clinical experience of the first author (HSA) who has directed mood and/or bipolar clinics since 1973; as well as the patient advocacy experience of the second author (KKA), who responded to various crises telephone inquiries from families and patients. This dual experience of both authors spans more than the illness itself in that it involves, among others, familial, social, educational, financial, and legal aspects. The principles we enunciate herein are not meant to be an exhaustive discussion of these issues but instead focus on the main areas that need to be taken into consideration for optimal outcome.

Although formal “manualized” therapeutic programs for bipolar disorder exist, they derive from specific theoretical perspectives such as cognitive-behavior therapy and circadian rhythms, or their application in psycho-education. These are valuable contributions summarized in this book, but are limited to specific areas of dysfunction in bipolar illness. In this chapter, instead of applying particular theoretical perspectives in the treatment of
bipolar disorder, we integrate therapeutic principles that we have learned from caring for bipolar patients and their families.

25.2 THE MAJOR PLAYERS IN BIPOLAR DISORDER

25.2.1 THE PATIENT

Although the depressive phase causes a great deal of suffering, both patient and family may initially ascribe it to misfortune, trauma, or love loss. Later they may invoke moral explanations such as “laziness.” But ultimately when depression fully declares itself, recurring on a cyclical basis, especially in the face of observable dysfunction and disability and suicidal preoccupation or attempts, it becomes inescapable that both patient and significant others will understand that these manifestations constitute signs of a veritable illness. Patients and families are more likely to accept help for the depressive phase.

The manic phase with its poor judgment and lack of insight robs the patient of the capacity to understand the pathological nature of excited behavior. Significant others, too, may initially misunderstand manic signs and symptoms as indicative of misbehavior due to youthfulness, hardheadedness, or erotic excesses. Ultimately parents recognize the excited phases to be the hallmark of the illness, leading to grave dysfunction, but not so with the patient who continues to insist that they are feeling fit and well and that there is nothing wrong with their behavior. One of the tragedies of bipolar illness is that considerable destruction of the social fabric of the patient’s life does occur as a result of numerous manic episodes (Krober, 1993) before they can be brought to accept treatment; some never do so.

Overall, the foregoing considerations suggest that if and when patients accept treatment it is likely to be for the depressive phase, that is, with anti-depressants which, in monotherapy, have the distinct disadvantage to switch the patient into the excited phase – or at least not to protect against it (Sachs et al., 2007) – thereby leading to increased cycling (Kukopulos et al., 1980) or mixed states (Akiskal and Mallya, 1987). Patients’ motivation to continue with mood stabilizers, often given during crises against their will, is rarely adhered to beyond a short period. Because they do not feel ill in their excited phase, they can find a myriad of banal “rationales” to discontinue their mood stabilizing medication. Unfortunately there is a litany of side effects that they can invoke to stop their medication.

The main conclusion to be drawn from the foregoing statement is that the cognitive dysfunction of bipolar illness (Balanzá-Martínez et al., 2010) – which unfortunately is not even in the criteria of DSM IV for bipolar disorder – represents the most handicapping aspect of the illness (Goldberg and Burdick, 2008). Such “illness agnosia” is the basis for the failure to understand the need for treatment, and is often associated with personal and social “deficits” (Akiskal, Azorin, and Hantouche, 2003a).

25.2.2 THE FAMILY

The cyclical recurrence of depressive and excited episodes is highly disruptive to family life. In addition, patients may use highly abusive language toward their loved ones.
Relationships with peers, especially of a romantic nature, are often strained, tempestuous and on a disaster path. Academic and professional promises are not fulfilled. The family is extremely frustrated and confused. Although they wish the best treatment for their bipolar member of the family, in the beginning years of the illness they may deny its presence because it is traumatic for the family to accept that yet another member of the family has come down with the illness. They hope and wish it will go away. Even if hospitalization is required, they may in the beginning opt against it to avert the stigma implied in psychiatric hospitalization for the affected member, as well as for the family at large.

Eventually the consequences of bipolar disorder become unbearable for the family – and dire for the patient. But the patient is typically unwilling to accept treatments involving restraints and imposition on their civil liberties. Such attitudes inaugurate the long phase of battles with family and significant others regarding the need for hospitalization and/or regular outpatient visits. These may eventually translate into legal conflicts between patients and the family. Not infrequently, these conflicts involve financial battles over inheritance, trust funds, and pensions. Under the worst scenario, adolescent and even older bipolar patients may accuse parents of inflicting trauma and emotional abuse – even sexual abuse (Akiskal, 2004). This is not to say that the latter never takes place. What is regrettable is that inexperienced or earnest mental health clinicians all too often take reports of “abuse” at their face value, instead of considering them as a reflection of the extreme emotional climate of a high expressed emotion (EE) family (Akiskal, 1996).

With chronically relapsing illness, it is often the mother who carries the brunt of the illness’ burden. Such mothers themselves typically go through periods of despair, hope, and denial about their adult bipolar children. This is often a lonely despair, about which kin not living with the family are ignorant of or indifferent to; at worst, such kin may even display critical and angry attitudes toward the caregiving mother (i.e., “You are a bad mother” or “you are not taking care of your sick child”), or even worse (“Your child’s illness is due to you having abandoned her”). Such criticism toward the mother is also routinely verbalized by the bipolar offspring, but unlike that of kin, may cycle into effusive expression of love and gratitude in a state-dependent fashion.

In the case of illness declaring itself in a marriage, separation or divorce is a common complication. Such individuals may return to their family of origin, where again the mother carries the burden of caring for an “adult child” – otherwise the patient may end up becoming institutionalized or homeless.

25.2.3 THE PSYCHIATRIST AND OTHER CLINICIANS

Nonpsychiatric physicians usually shun away from bipolar illness as a specialized area. Also many clinical psychologists consider bipolarity to represent the domain of psychiatry. This is fortunately gradually changing. Psychologists are increasingly assuming an important role on the therapeutic team in the long-term care of bipolar patients. The same is even truer for social workers, nurses, and doctors of pharmacy, who in today’s
mental health care system represent a cadre of valuable and essential members of bipolar or mood clinics.

Although psychiatrists during their training do gain experience in diagnosing and treating this illness, most university medical centers do not offer specialized training in bipolar disorder. As a consequence, unless a psychiatric trainee has a special interest in this area, his or her experiential base in this disorder is likely to be less than optimal, in particular, they gain little hands-on experience in the long-term care of bipolar patients.

Patients and their families are always seeking information to understand this illness and its frustratingly complex course. One of the most difficult problems for the patient and the family is to find the “right psychiatrist” who can manage bipolar disorder. That the number of such psychiatrists is relatively small, is not the fault of the psychiatrist, but rather the lack of vision in graduate medical education. Much of what most psychiatrists do in their clinical practice involves affective disorders in the broad sense, yet their formal educational curriculum does not reflect this. “Neurotic” and depressive disorders are relatively easy to comprehend and manage, and illnesses like schizophrenia and dementia have the veneer of organic disease, whereas bipolarity has such a complex interplay of social and occupational behavior that is less fathomable for the average psychiatric trainee. Their lack of exposure to phenomenology, psychology, pharmacology, and long-term course of bipolar disorder creates a major public health problem. So-called “classic bipolar” disorder is a platonic myth – from which most patients deviate in significant ways. An inexperienced clinician then will often misattribute bipolar disorder to other mental disorders such as schizophrenia, anxiety and unipolar disorders, or personality disorders (Akiskal and Puzantian, 1979; Hirschfeld, Lewis, and Vornik, 2003; Hantouche and Akiskal, 2004). Sadly, the cross-sectional erratic behavior of bipolar patients is often labeled “borderline” – if not frankly “psychopathic.” Such labels alone will militate against any meaningful long-term alliance of patients with clinicians. Despite protests to the contrary, bipolar disorder remains under-diagnosed and under-treated (Albanese et al., 2006; Zimmerman et al., 2008; Smith and Ghaemi, 2010).

There are reasons to believe that continuing medical education programs focusing on bipolar disorder are beginning to positively impact the recognition and treatment of bipolarity in its broad expressions. There now exist pockets of clinical excellence in bipolar disorder and, refreshingly, many are in practice settings outside academia.

25.2.4 THE MOOD/BIPOLAR CLINIC

In part because of the reasons just discussed, there exist very few mood and or bipolar clinics in the world. Of the few existing ones, nearly all are located in the United States. They used to be called “lithium” clinics (Fieve, 1975), because rigorous use of lithium with due attention to medical aspects and blood levels was mandatory. This helped in the medicalization of bipolar disorders at a time when psychiatry was basking in psychodynamics. However, positive results with lithium were largely limited to bipolar patients who were willing to adhere to the relatively tight regimes required. These clinics were crucial for adherence to the prophylactic use of this agent (Akiskal, 1999) and suicide prevention (Muller-Oerlinghausen, Grof, and Schou, 1999).
Mood clinics had a broader agenda and emphasized integration of different therapeutic modalities. Although this was more congruent with the emergence of an “eclectic psychiatry,” mood clinics did not become popular perhaps because they competed for the clientele of psychiatrists in both academia and general practice. In the process, what psychiatry missed was the opportunity for mood clinics to train residents and fellows to become specialists of mood disorders. In such clinics, routine prospective follow up revealed high rates of transformation of depression into bipolar disorder (Akiskal et al., 1983), particularly bipolar II subtype (Akiskal et al., 1978; Akiskal, 2005). This would have liberated psychiatrists from the rigidity in our formal diagnostic system for mood disorders where patients fall into the unipolar and bipolar molds. In clinical reality, most affectively ill patients fall in a spectrum between these extremes (see Chapter 2). But to properly appreciate this perspective, the clinician must experience over prospective follow-up, the gradual – though at times subtle – transformation of unipolar patients into soft bipolarity. Family history, especially when buttressed with family interviews, will further inform the psychiatrist where DSM-IV and ICD-10 fail abominably – as the proper diagnosis of bipolar disorder needs to be continuously revised by the evolving nature of affective and related disorders in family members. It is also important to appreciate that mood patients over prospective observation develop what otherwise might be regarded as “unusual” – namely, the common development, among others, of psychotic, panic, phobic, obsessive-compulsive, dysmorphic, bulimic, addictive, and impulse-control disorders (Perugi, Toni, and Akiskal, 1999). Such complexity is the rule, rather than the exception. Short of such an exposure to the familial and longitudinally evolving nature of affective illness, the psychiatrist in training could not gain optimal experience to the most common types of bipolar disorder. Furthermore, in such a setting a team of mental health professionals could bring their knowledge and experience to bear upon the treatment of these patients. Thereby, a therapeutic relationship would be forged between the patients, their families, and the clinic at large, including the trainees. This is a good scenario for treatment adherence – and makes caring possible.

The situation is different with the current bipolar programs in many academic centers which are primarily focused on industry supported pharmaceutical research and secondarily on research related to the psychobiology of the illness supported by National Health Institutes. Most of these programs are at the mercy of the vagaries of funding, which means that neither the staff nor the patients have long term continuity. This is a sad scenario, which does not take the lifelong nature of the illness into consideration. This is not to say that bipolar programs as they exist today do not advance knowledge. On the contrary, a great deal has been learned about the illness itself and its treatment – witness the large number of new treatments introduced over the last decade and a half, and which is the theme of this book. The problem is that most studies do not address the long term care of the patient. Even collaborative or cooperative programs from funding institutes – which have the luxury of longer follow up – do not primarily focus on the long term care of the patient, and sadly spend little funding to train specialists in bipolar disorder. Most research scientists who, by the very nature of their funding, train interviewers or raters of psychopathology rather than clinical practitioners. As a result, they produce research administrators who know more about methodology, institutional review boards and the art of “grantsmanship” than caring for bipolar patients.
Interestingly, there has been some interest to develop mood and bipolar clinics in private practice settings, including at least one in the setting of primary general medical care (Manning, Hyakal, and Akiskal, 1999). The primary care clinic in general medical settings provides an optimal opportunity for early detection of bipolar disorder. In this setting, Dr. Manning, in collaboration with the present authors’ team, used the temperament evaluation of Memphis, Pisa, Paris, and San Diego (TEMPS) to detect subtle and early manifestations of bipolar disorder at the temperamental level (Akiskal et al., 2005). In nonpsychiatric medical settings, it is more practical to use this instrument rather than instruments that detect hypomania, which require more formal psychometric understanding (Benazzi and Akiskal, 2009).

A pessimist might conclude that the gap between those who actually care for bipolar patients and those who do research on how to care for such patients is widening. An optimist might point out to a large volume of an increasingly sophisticated literature on caring for bipolar patients and their families, particularly from psychoeducational (Colom et al., 2003) and collaborative care model (Bauer et al., 2006) perspectives. The real question though is why psychiatry has not yet developed a sufficient number of mood or bipolar clinics to accommodate the somatic and psychosocial needs of these patients in an integrated fashion. That patients and families with bipolar illness have long been frustrated in this respect is perhaps the main driving force for the development of bipolar advocacy organizations.

25.2.5 MENTAL HEALTH ADVOCACY ORGANIZATIONS

The foregoing challenges, as well as the need for a long-term perspective led to the development of such organizations – several of which are devoted to depressive and bipolar disorders. They promised self-help support, education, destigmatization, advocacy for better services, advocacy for relevant research and administering research awards that are advancing knowledge about the needs of patients rather than mere theoretical or basic science developments. These lofty goals are obviously helpful for patients as well as for their families, and could impact public health (Lish et al., 1994). Unlike the Alcoholics Anonymous model, these organizations typically endorse a spectrum of therapeutic modalities that span from the psychopharmacologic to the psychotherapeutic. Many members of these organizations also often seek the assistance of their local Alcoholics Anonymous chapters.

The major downside of these organizations is, because their main advisors, tend to be high level researchers rather than clinicians involved in the day to day care of patients. Optimally, both researchers and clinicians should be represented on these advisory boards. Advocacy organizations are vulnerable to the tensions and conflicts inherent to large organizations, including the inevitable clash of temperaments of its executive members. Nonetheless, these organizations have succeeded in bringing strong clout to the cause of de-stigmatization of bipolar disorder and the need for new research to both governmental and industry sources. In the United States, it has even become possible to have one rubric, the National Alliance of the Mentally Ill, to serve as a unifying
voice for the mentally ill at large. Moreover, the National Alliance for Research in Schizophrenic and Affective Disorders (NARSAD) has sprung from the ranks of affluent families with offspring suffering from these disorders to become the world’s leading charity dedicated to mental health research. It supports both established and promising investigators in their pursuit of innovative research leads in etiology, pathogenesis, and innovative treatments.

25.2.6 SOCIETY AND THE MEDIA

Bipolar patients are poorly understood by the public at large. This is generally true for all serious mental illness, but there are two aspects rather unique to bipolar disorder, and which often find resonance in the media. The first is that bipolar individuals are over-represented in the corporate world and in politics: scandals in the sexual and financial arena, so alluring to the media and to the public at large, tend to give a “bad name” to the illness. The other one is the tendency of some researchers and media to glamorize bipolarity as a “genius disease,” especially in the artistic domain and theoretical science. This is problematic because such benefits characterize a minority of patients, usually at the soft end of the spectrum (Akiskal and Akiskal, 1988) or among the “unaffected” relatives of bipolar patients (Coryell et al., 1989). Many patients are disappointed that their doctors are unable to help them reap the “benefits” of their illness. If not properly handled, this may create mistrust between the doctor and the patient. This could also generate conflict between bipolar patients, their employer and institutions in which they work. Patients may feel entitled to advantages and even tolerance for their outrageous behavior on the grounds that manic-depression confers creative spurts upon them. While greater understanding of bipolar disorder has occurred recently, this does not necessarily translate into greater tolerance of the irregular work habits of bipolar patients.

25.3 PRINCIPLES OF CARING

1. Bipolar illness is a disease with strong genetic determinants which is exacerbated and complicated by psychosocial factors. Competent pharmacotherapy must be matched with sophisticated yet practical psychosocial interventions. There is no longer such a philosophical divide between the two (Mundt, 2003; Fuchs, 2004). “Medication visits” are necessary but insufficient: Quality time is needed to explore and address psychotherapeutic issues (Table 25.1). However, such lofty goals are more easily articulated than carried out. In current practice, especially in public mental health settings, pharmacotherapy and psychotherapy are disassociated, thereby making their integration difficult. Combining them in one person, obliquely a physician, has the disadvantage that psychiatrists may not have all the requisite skills for the newly developed unwieldy list of psychosocial interventions and, even if they did, it may be impractical for one person to administer them all. The so-called “team approach” is an optimal compromise, but has the danger of becoming administrative rhetoric rather than a genuine forum for integration. To
Table 25.1 Psychotherapeutic issues in bipolar disorder.

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<th>Issue</th>
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<tbody>
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<td>Denial of the illness</td>
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<td>Developmental delays and emotional immaturity</td>
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<tr>
<td>Uneven careers, talent, and creativity</td>
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<td>Financial extravagance</td>
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<tr>
<td>Burden on the family</td>
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<tr>
<td>Risky sexual behavior</td>
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<tr>
<td>Marriage, pregnancy, genetics</td>
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<tr>
<td>Stigma about chronic illness</td>
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<td>Effects of bipolar medications on temperament</td>
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<tr>
<td>Fears of return of illness episodes</td>
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<tr>
<td>Battle over control of the self</td>
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<td>Self-regulation and regulation of self-esteem</td>
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Table 25.2 Factors in treatment non-adherence.

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<th>Factor</th>
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<tr>
<td>Cultural: stigma, anti-medication attitudes</td>
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<tr>
<td>Illness: no insight, mania, initial episodes</td>
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<tr>
<td>Comorbidity: alcohol/drug abuse</td>
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<tr>
<td>Medication: unacceptable side effects</td>
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<tr>
<td>Patient: young, low socio-economic status male, missing highs</td>
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<tr>
<td>Family: lack of supervision</td>
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<tr>
<td>Physician: inexperience, inconsistency, or hiding behind authoritarian attitudes</td>
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<td>Health climate: undermining continuity of care</td>
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make things worse, patients and families may disrupt the precarious balance of integrated treatments. That’s why treatments for bipolar patients must be administered by visionaries committed to practical tasks – a rare blend of talents.

2. **Availability of family members or significant others** who are willing to participate in the therapeutic process, who can monitor adherence to treatment, provide information about the course of illness under treatment and could be trusted during times of crisis. Such support and participation is crucial in bipolar disorder with its proverbially unpredictable exacerbations. Patients’ denial of illness and reticence to seek help represent major factors in relapse, and the pivotal role of a caring family cannot be underestimated in this regard; adherence to treatment is a complex subject (Table 25.2); also see Jamison and Akiskal (1983). In the authors’ experience, love and respect for or dependency upon a significant other or an authority figure in the family is crucial for treatment adherence.

3. The attitude of significant others which is of the greatest help is one of concern and **emotional warmth while maintaining objectivity**. Given the tempestuous interactions that occur in this illness, individuals close to the patient cannot avoid being – or coming across as – critical. While it is true that critical attitudes may
lead to further exacerbation of the illness – particularly depression – it would be unrealistic to think that they would not occur. It is warmth that counterbalances critical attitudes whether in bipolar disorder or schizophrenia (Okasha et al., 1994), representing an important vehicle in facilitating caring.

4. Feedback by peers – meaning by other bipolar patients and other bipolar families – is often more effective than that given by professionals and the patient’s immediate family. This means that exposure to peers in a format such as **group therapy** (Table 25.3) can play a fundamental role in combating denial (Graves, 1993).

5. **In mood charting** (which Kraepelin (1921) pioneered and in more recent times was introduced into clinical science by Robert Post [2008]), life events and prevalent mood on a daily basis can help the patient understand the connection of such moods to life events, for example, hypomania to sexual unfaithfulness, irritable mood to loss of job. However, unwieldy methods of charting deriving from research protocols are not of much use in routine practice. Mood charting is best individualized to make sure that it is patient-friendly.

6. **Limit setting** can be achieved through the group therapeutic process. However, in some instances, only a close family member can be trusted to place such limits. We are specifically referring to delegating financial control at critical junctures to a spouse, parent, or sibling. This pertains, among others, to checks, credit cards, and inheritance. As for the latter, lawyers may be necessary to protect the patient’s and family’s respective rights. In this endeavor, one must rely upon lawyers whose loyalty has been tested beforehand. Tragically, impulsive spending often leads to financial ruin before such measures are instituted. Mental health professionals regrettably have little or no training in such matters. The authors are familiar with cases where lawyers, instead of being patient advocates, further depleted the patients’ financial means.

7. **Functioning is more important than mood stabilization.** While rapid control of mania in the acute phase is desirable, over-stabilizing patients with “aggressive” pharmacotherapy is unlikely to lead to treatment adherence in the long run. It is best if the psychiatrist “goes halfway” in meeting reasonable requests by the patient about dosage and the optimum mix of medications. Implicitly, the psychiatrist will still have the “upper hand” from a medical point of view, while permitting the patient some participation in the therapeutic choices. Once recovered from major episodes, permitting some degree of self-management is a valuable but difficult
goal to attain. Vigilance is necessary to make sure that the patient doesn’t take this as a mandate to do as he or she pleases, while at the same time reassuring that the psychiatrist is aware of the difficulty the patient has in entirely surrendering the control of the self to some “ideal” of stabilization that is in a textbook’s or guidelines’ doses or blood levels. For instance, while it is true that better control of bipolar episodes is achieved with high lithium blood levels, most patients cannot tolerate such levels, hence they stop it (Gelenberg et al., 1989). In summary, the goal of treatment is not to aggressively overmedicate the patient to mediocrity; the psychiatrist should endeavor to help patients attain their best functioning without risking relapse. This is a more delicate art than helping patients maintain optimum blood pressure or blood glucose. But the “battles” over chemistry and health between patients and doctors as to who controls or is in charge of the patient’s temperament, life, and soul are analogous in principle in both internal medicine and psychiatry. The art of managing such matters, while fundamental in our teaching efforts, is difficult to transmit – yet they must be practiced. This is what makes being a doctor fundamentally different from being a scientist. It is amazing how the current craze for scientific medicine continues to obscure this difference. Our point is that the issues involved are not unique to psychiatry, and to express our reservation to the complacency of many in our field who feel that “evidence-based” guidelines represent a sufficient measure for practice.

8. It follows then that for the patient to trust a psychiatrist, he or she must respect the patient’s temperament and individuality, that indeed his or her aim is to bring out the optimum of what is positive and desirable in patients’ temperament in terms of interpersonal charm and professional achievement (Akiskal and Akiskal, 2005). Nonetheless, as alluded to earlier, it is generally best to downplay literature about bipolarity as a “genius disease.” First of all, “genius” is multi-factorial and if it is associated with bipolarity, it is generally at the soft end of the bipolar spectrum and not at the psychotic end (Akiskal and Akiskal, 1988, 2007, 2010). While it is understandable that some literature advocates the idea that bipolar individuals are very successful individuals in the arts and other domains (Jamison, 1996; Arnold, 1995), the intent of this literature is best understood as an attempt to de-stigmatize the illness. The unfortunate fact is that despite many positive attributes, the majority of ill bipolar patients cannot be expected to be creative or eminent unless they are independently gifted – and the course of the illness permitting. In our report from a large urban mood clinic (Akiskal and Akiskal, 1988), “creativity” (which was liberally defined) was limited to basically 8% of bipolar II. Should too much be made of the prospects of eminence in bipolar disorder in a given patient, the patient may feel cheated that the psychiatrist and the team of mental health workers somehow failed in bringing the best in him or her.

9. Comorbid personality disorder – particularly the “B label” – is best handled by not diagnosing it, as more often than not, it is a reflection or complication of the illness (Akiskal, 2004). The emphasis must be on rigorous treatment of the bipolar illness itself. We have elsewhere shown that the use of temperament constructs is much more germane to understanding bipolar disorder, as they identify traits which
make individuals vulnerable to the illness, while at the same time fostering adaptive function (Akiskal, 1992; Akiskal et al., 2005). Family members, like psychiatrists and psychologists, in their frustration often invoke characterologic factors to explain the unproductive or “bad” behavior of their bipolar kin. It is best to conceive of such behavior as “faulty habits” that maintain the illness or are developed to deal with it. Addressing such habits with behavioral interventions is more likely to lead to change in the desired direction than characterologic labels that fault the patient and exculpate the clinician. Social workers can play a vital role in this process as they are more likely to be Meyerian in philosophy.

10. Because psychiatric tragedies, including social scandals, often occur in the lives of bipolar patients, the psychiatrist must be available at times of crisis. A nonjudgmental attitude by the psychiatrist when all others are “attacking” the patient would assure to enlist the patient’s cooperation in solving the crisis with minimal consequences (Akiskal, 2000). Being nonjudgmental however does not mean that the psychiatrist is condoning the behavior that led to the crisis. Because such crises often stem from poor judgment due to (hypo)mania or depression (more often the former than the latter), the psychiatrist must attempt to steer the patient out of the crisis rather than wait for the patient to find his way out.

11. Related to the above, and given the fact that depression is more painful subjectively and less likely to impair insight than hypo-mania, outcome of prophylactic treatment is, in our experience, more likely to be associated with better adherence when initiated during the former. Despite one study favoring such a conclusion (Lenzi et al., 1989), there is surprisingly little systematic data on this very critical subject. Thus, more attention needs to be paid to phase-specific pharmacologic treatments, such as Koukopoulos’ notion, that “mania-depression-free interval” patients do better on lithium than those with “depression-mania-free intervals” (Koukopoulos et al., 1995).

12. The most serious crisis in bipolar disorder is suicidality. The clinician should err on the safe side and consider admitting the patient to the hospital. Electroconvulsive therapy is an option which often proves to be life-saving. Faced with a suicidal bipolar patient, half-baked theoretical or existential discussions must be avoided. Although lithium is touted to be unique in its antisuicidal properties (Goodwin et al., 2003), probably most, if not all, approved agents for bipolar disorder are as effective (Angst et al., 2002). Depressive mixed states (Benazzi and Akiskal, 2001), intrusion of hypomanic features into depressive episodes, is one of the most treacherous substrates for suicidality, because of the subtle nature of the mixed state. In our experience, such patients respond best to Ziprasidone, Olanzepine, or Divalproex.

13. The psychiatrist should avoid taking a Calvinistic approach to alcohol and substance use. Thus, one must not be unreasonable in prohibiting alcohol and/or marijuana which based on occasional use has not shown to have destabilized the patient. However, abstinence from stimulant agents, including caffeine, is mandatory. Opiate-dependent patients can be stabilized on methadone (Maremmani et al., 2003).
14. Many bipolar patients, even in their trait condition are “activity junkies” (Akiskal, 2005). Unfortunately, most types of excessive activation – whether it is spending money, frequent travel, excessive risk-taking in sex, drugs of abuse, gambling, working two to three shifts – can destabilize them. The destabilizing effect of activation is also pertinent to therapeutic agents for depression – and we are specifically referring to antidepressants. They should be used sparingly, for rigorous indications (that is, severe or suicidal depression), and only for as long as needed. Thus, **antidepressants should almost always be administered along with mood-stabilizing or anti-manic medications**. “Bipolar-friendly” antidepressants (for example, bupropion) might be preferred, but even these are not entirely safe – from a switching standpoint – in monotherapy. Lamotrigine may prove to be a viable “antidepressant” for many acute bipolar depressions, and this may be particularly true for bipolar II.

15. **Sleep hygiene** is an important ingredient in the overall management of bipolar disorder. However, because yearning for freedom from time constraints (rhythmopathy) is part of the core pathology of the illness, it often remains an elusive goal. Pragmatic approaches are preferred over unwieldy protocols developed in chronobiology labs. Nonetheless, understanding of chronobiologic principles can help to develop individualized circadian approaches in situations of shift work and jet lag. Useful approaches to the rhythmopathy include total darkness which should enhance sedating pharmacotherapy to prevent sleep deprivation and maintain restorative sleep. Thus, given the anxious arousal and insomnia or decreased need for sleep in bipolar disorder, rather than solely depending on behavioral management, it is often desirable to use sedating properties of existing anti-bipolar agents to treat anxious arousal at night. By the same token, although it is best to treat bipolar patients combining approved medication for the bipolar indication – or those with evidence from controlled studies – an appropriate exception can be made for agents such as gabapentin or clonazepam, as possible augmentation agents for anxiolysis, or sleep restoration.

16. The same remarks apply to topiramate as an agent for weight reduction. **Weight management and associated metabolic issues** represent a relatively new challenge, and must be rigorously addressed. When weight is a major concern, although one must preferably use weight-neutral approved medications for bipolar disorder (for example, Carbamazepine, Lamotrigene, Aripiprazole), this should not be at the expense of effectiveness. That is, if a bipolar patient responds best or exclusively to medication which leads to weight gain, it may sometimes be disastrous to substitute it with weight-neutral medication. Thus, rather than risking destabilization, the psychiatrist must consider concurrent weight management. This is obviously an art in which the field of medicine at large has yet to prove its worth in terms of long-term effectiveness. But one can learn something by trying different approaches which may fail in some, but work in others. In our experience, “diet” is a term that elicits frustration. Lifestyle changes, such as incorporating walking in one’s daily routine, are more likely to be rewarding and effective.

17. Bipolar disorder is multidimensional and requires **rational polypharmacy** working on different substrates, which means that anti-psychotics, anti-convulsants, and
mood stabilizers are often to be combined. Because abrupt withdrawal of an agent from the medication regimen is likely to lead to premature or early relapse, it is generally best to augment rather than substitute agents in the medication regimen.

18. **It is generally futile to meddle with the patient’s love life**, for this is hardwired! Nonetheless when the erotic life is tempestuous to such a degree it is causing extreme pain and suffering or it is hopelessly or delusionally fixated on unavailable love objects (erotomania), an open discussion can prepare the ground for exploratory psychotherapy. Regrettably, antipsychotics which reduce sexual desire may have to be used in some instances.

19. A great deal of research, covered in this book, supports the use of psychoeducational practices in treatment adherence and in reducing denial. What this literature does not sufficiently emphasize is that **psycho-education is a two-way street**. The doctor himself or herself must learn about the patient and his or her disease, not from textbooks, but from direct daily interactions with the patient and his or her family.

20. Side effects of medications are sometimes intolerable and may necessitate adjustment of dosage or even substitution with a better tolerated medication. However, **in a patient whose illness has been brought under reasonable remission, it is best not to make major adjustments in the medication regimen**. The risk of relapse is a more serious concern in this instance than the nuisance of certain side effects. This is a situation when the therapeutic relationship with the physician is extremely important for the patient to trust his or her judgment on this matter, namely that it is not always possible to eliminate all side effects, and once “good enough functioning” has been achieved, it is best not to risk destabilization. Nonetheless, all reasonable efforts must be made to make sure that all adjustments are made to assure that side-effects are tolerable enough to not compromise adherence. The principle here is **meeting the patient half way**.

21. However, **periodic minor adjustment of medication can be considered at times of expected major stress**, including circadian stress such as trans-meridian travel, or when past course has revealed seasonal exacerbation, or specific psychosocial situations leading to relapse, proper upward medication adjustment should be prescribed at the expected time of the occurrence of these stressful events.

22. **Supporting the family, the spouse, or other carers – and particularly the mother** – of bipolar patients is a cardinal principle that is often neglected in contemporary psychiatry. Not only is this necessary to make sure that the patient has an effective support in the family, but to prevent the family from breaking down. Family members of the patient often carry the same bipolar genes in dilute form, compared to that of the patient, and it is the stress of being exposed to an extremely ill offspring that for the first time brings about depression in the mother. Illness of one’s offspring, from an evolutionary standpoint, represents an extreme stress for a woman. It is such stress operating on a modest genetic vulnerability that brings about a depressive outcome for the mother. Support to the family often requires individual or group therapy. Patient advocacy organizations can also play a vital role in this respect.
23. The value of **genetic counseling** is limited, because patients in our experience typically present after the fact (that is, when pregnant). The risks of bipolar medication for the fetus, especially that of lithium, in our experience are exaggerated. Nonetheless, pregnant bipolar patients may require careful assessment in consultation with gynecologists or specialized women’s bipolar clinics which have experience in such matters. Prospectively identified patients, which can be accomplished in a mood clinic, can be provided with risk estimates for offspring, especially when family history is loaded with affective illness or has pedigrees with psychotic bipolar illness and/or suicide.

24. Bipolar patients are preferably treated in group practice. Such a setting will provide the opportunity for consultation from colleagues, or time limited appointments with other members of the team when the primary physician is on vacation or ill. This could help in diluting negative transference reactions, while at the same time giving the patient the benefit of a second or third opinion. Ideally however, and especially in the public domain where most bipolar patients are treated, a **mood or bipolar clinic** provides many advantages (Table 25.4). Such clinics provide an experienced, sophisticated multi-disciplinary team including psychiatrists, psychologists, social workers, nurses, and doctors of pharmacy. Not only does the team provide greater variety of treatments tailored to the different needs of the patient, but it is better able to assure adherence, longitudinal care, and prevention. It also provides a resource for other mental health professionals in the community. Thus a patient can have pharmacotherapy, psycho-education, individual psychotherapy, group therapy, behavioral therapy, and social interventions. Of all the psychosocial treatments, psycho-education has the best data-based status, and has been covered elsewhere in this volume. In the mood clinic setting it is also possible to provide support for the family care givers, making sure that they become acquainted with the psychological and social skills to monitor the patient’s progress. Finally and most importantly, the setting of a mood clinic provides the opportunity to observe and diagnose illnesses in family members before they fully declare themselves. This could include spouses, siblings or children (Akiskal *et al*., 1985a). This is of immense public health importance, yet it has been insufficiently capitalized in psychiatry (Berk *et al*., 2010). This is regrettable given the inexorable course of the illness once it develops into full steam. Finally, secondary prevention can be achieved by family members identifying early signs of impending relapse. Patients

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<th>Table 25.4 The role of a mood or bipolar clinic.</th>
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<td>Combines service, training, and research</td>
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<td>Experienced multi-disciplinary staff</td>
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<td>Focus on the family or couple</td>
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<td>Sophisticated treatment</td>
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<td>Better treatment adherence</td>
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<td>Longitudinal care</td>
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<td>Prevention</td>
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<td>A resource for other mental health professionals</td>
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can also be taught to monitor their own behavior and mental state in achieving this goal. A combination of the two sources of information is needed, because in general caregivers might be oversensitive in identifying signs of a relapse, while patients often are less inclined to do so.

25. **Maximize treatment adherence.** The principles we have discussed will be defeated if reasonable treatment adherence is not achieved. Indeed, these principles should contribute significantly to such adherence. The following can help further maximize adherence: Educating both patient and family about early signs of relapse, monitoring adherence to medication, making sure appointments in the clinic are kept, minimize dosing frequency, tailoring medication side-effects to those which are least likely to interfere with a patient’s functioning, medication support group therapy, and of course, psychoeducation.

25.4 **SPECIAL CONSIDERATIONS FOR HYPOMANIC AND CYCLOTHYMIC PATIENTS**

Much of the literature in the treatment of bipolar disorder is focused on bipolar I. In this section, we discuss adherence issues particularly relevant to hypomania, as well as special psychological problems posed by cyclothymic patients.

Bipolar patients are notoriously nonadherent with maintenance oral medication (Jamison and Akiskal, 1983). Many patients whose mood swings are attenuated by medication may complain of feeling “flat” (especially with lithium) because of a relative depression; others may describe memory problems, which are not easy to document. In such cases, it is necessary to rule out atypical relapses without vegetative signs or lithium-induced hypothyroidism (especially in women). The latter is best accomplished with the TRH stimulation test. Other patients complain that the loss of hypomanic drive and indefatigability adversely affects their work and relationships.

Couples therapy may be indicated when treatment results in decreased assertiveness in a patient who previously took an active role in sexual and social activities. Other patients may complain of decreased productivity and creativity. However, a systematic survey conducted by Schou (1979) among artists showed actual decreases in creativity to be uncommon; indeed, more often than not, lithium offers the opportunity for more “even” periods devoted to interpersonal, scholastic, professional, and artistic pursuits. Recent data shows lithium-induced gray matter volume increases to underlie treatment response (Lyoo *et al.*, 2010).

Adherence can often be enhanced by using the lowest possible dose that is compatible with freedom from major episodes, without necessarily preventing all mood oscillations. Another strategy is to combine two medications with different mechanisms of action and side effect profiles, but administering each at “sub-therapeutic doses,” which would be synergistic and therapeutic in combination. A trial-and-error period, during which the patient’s mental status is closely followed, is necessary to establish such a balance. This approach is especially welcome by those bipolar patients who enjoy hypomanic moods.

Many bipolar patients have considerable psychological assets, such as personal charm, affective warmth, creative bent, and a high drive to fight for or advance various causes.
These assets can often be capitalized in attempts to reconstruct lives that have been shattered because of impulsiveness and poor social judgment. In general, depth interpretations are unlikely to change these impulsive excesses, and voluntary control of such behavior is desirable - for example, turning over the checkbook to the spouse (Akiskal, Khani, and Scott-Strauss, 1979).

The foregoing issues are particularly relevant in the treatment of the spectrum of bipolar II disorders. Because these conditions begin at an early age and pursue a periodic lifelong course, they may be mistaken for primary characterological disorders. These soft bipolar conditions are distinguished from the classical (or so-called major) mood disorders in that their baseline manifestations are subsyndromal, intermittent, and typically lifelong. That is, in the patient’s habitual condition, the affective psychopathology does not necessarily crystallize into discrete episodes. However, clearcut and unmistakable syndromal episodes are not uncommonly superimposed on the lifelong course of these temperaments. It is this very intermittence that creates their resemblance to personality disorders. This is further reinforced by lifelong maladjustment in scholastic, occupational, and conjugal areas, secondary to chronically unstable and unpredictable moods. Finally, the mood change is often quite subtle, with behavioral and personal disturbances dominating the clinical presentation. For instance, in the University of Tennessee study of cyclothymic depressives (Akiskal et al., 1977), affective manifestations were masked by interpersonal crises. Repeated marital failure or romantic breakups, episodic promiscuous behavior, alcohol and drug abuse, uneven work and school record, geographic instability, and dilettantism were the cardinal reasons for which these patients had come to clinical attention.

Unpredictability of moods is a major source of distress for cyclothymic individuals, who can’t predict from one day to the next how they will feel. This undermines their sense of self and gives rise to apprehension, even during euthymic periods (Akiskal, Khani, and Scott-Strauss, 1979). Indeed, this temperamentally propensity to change from one affective state to another with very little ego control over the change is one of the principal reasons why some psychodynamically oriented clinicians may consider cyclothymic and bipolar II disorders as an expression of “borderline” characterological psychopathology. Old and current data (Akiskal et al., 1985b; Deltito et al., 2001; Akiskal, 2004; Smith, Muir, and Blackwood, 2005) suggest that in many cases the direction of causality is in the opposite direction, that is, that borderline features arise from the affective instability. Mixed states of short duration with extreme irritability occur in all subtypes of cyclothymia and are often associated with sedative hypnotic and alcohol abuse. Borderline characterological psychopathology is usually most severe in cases in which such irritable periods predominate. These irritable cyclothymics (Akiskal and Mallya, 1987; Akiskal, Hantouche, and Lancrenon, 2003b) are habitually moody-irritable and choleric with infrequent euthymia; they tend to brood; are hypercritical, complaining, and obtrusive; and typically evidence dysphoric restlessness and impulsivity.

In view of their propensity to affective recurrences, cyclothymia and bipolar disorder NOS are at high risk for having stormy object relations, which often give rise to serious interpersonal disturbances. While these disturbances warrant considerable psychotherapeutic attention, such attention may prove futile in the absence of competent pharmacotherapy of the affective instability.
25.5 CONCLUSION

There has been a revolution in the epidemiology, clinical phenomenology, classification, pharmacological, psychotherapeutic, and public health aspects of bipolar disorder. Indeed, bipolar disorders can now be considered to constitute a **subspecialty in psychiatry**. This is particularly true given the lifelong nature of the illness, the unpredictable exacerbations, and the disruption in social, occupational, and conjugal life, substance and medical comorbidity, and the high risk of suicide. Such an illness requires a coordination of services involving psychiatrists, nurses, social workers, psychologists, and pharmacists. It is no longer possible to think of solo practice in the management of this illness. The spectrum aspects require attention to diagnostic sophistication, not only in the patient, but also in the family, serving the cause of early case detection. This would be a model of practice that is necessary to teach training psychiatrists and other mental health professionals. The substantial advances in science are unlikely to make any impact on prevention and public health without such clinical units.

Regrettably, some bipolar programs deliver research rather than care. It is the latter aspect that now needs to be instituted. For this to happen, there needs to be “political” change in the climate of academic psychiatry and public mental health. What we need is the proper structure of caring for the affectively ill, mood, or bipolar clinics – just as there exist diabetes clinics, glaucoma clinics, pain clinics – multidisciplinary clinics that conduct research, train specialists, while providing high quality care.

The worst scenario for bipolar patients is that the lack of structures for caring for them in the current shortage of psychiatric beds is creating a new asylum on the streets of “civilized nations,” such as the United States, in the form of homelessness (Health Care for the Homeless Clinicians’ Network, 2000) – or worse, turning the mentally ill into prison inmates, which is particularly a very serious problem for bipolar with polysubstance abuse in the states of Arizona and California. Such incarceration is contrary to the spirit of Pinel’s (1809) humanitarian reforms which unchained the mentally ill and liberated them. Such liberation envisaged the right for hospital treatment when needed. It was not a blanket endorsement for keeping patients out of the hospital under any circumstances. Today the severely mentally ill are roaming in the streets and are liable to all the hazards and abuses of such an existence. Civilized nations must not tolerate such outcome for those unfortunate members of its society who are bipolar, **psychotically** ill and poor. There was a time when medical schools cared for the disadvantaged. Today, they erect proud institutes of molecular biology, cancer, and cardiovascular health. Modern psychiatry began two centuries ago with a humanitarian revolution, followed by one of understanding the mind, culminating in the psychopharmacological revolution. A major theme of this book is an eloquent example of the success of the latter paradigm as it pertains to bipolar disorder. Bipolar disease is a spectrum of genetically-based illnesses and, without competent modern pharmacotherapy, it is hopelessly impossible in most cases to attenuate its cyclic course and provide a life relatively free from major episodic eruptions, despair, and suicide. What we now need is a culture of caring within a broader social psychiatry. For psychiatry which does not safeguard the basic dignity of every man or woman with serious mental illness in not psychiatry at all.
Basic research is being pursued in bipolar disorder along many fronts. The most promising leads, in terms of understanding the causes and pathogenesis of bipolar disorder would probably come from genetics. Our team has identified genes for bipolar disorder, which pertain to their temperamental substrates (Greenwood et al., 2009). Such leads might eventually facilitate early diagnosis and prevention.

Today, many young psychiatrists and psychologists, aspiring to emulate their academic seniors in universities and research hospitals, measure prestige and success in multimillion dollar grants, and/or the limelight in national and international congresses. Ultimately, what we lecture about (“teach”), write, and do, must be measured against a less “prestigious” but more humane goal of caring for patients on a daily basis. The names of such dedicated mental health professionals are typically absent from the list of lecturers in national and international symposia on bipolar disorder – and their names do not adorn the pages of this book. We dedicate this chapter to them.

References

Overview of Principles of Caring for Bipolar Patients


