

Sample Topic

Bipolar Affective Disorder



The Medical Disability Advisor: Workplace Guidelines for Disability Duration

Fifth Edition

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Bipolar Affective Disorder

Related Terms

- Affective Bipolar Disorder
- Bipolar Mood Disorder
- Depressed
- Manic
- Manic Depressive Illness

Medical Codes

- ICD-9-CM: 296, 296.4, 296.7
- ICD-10: F31.6, F31.7, F31.8

Definition

Although bipolar affective disorder is classified as a mood disorder, the condition also affects cognition and behavior and frequently is complicated by psychotic symptoms (e.g., delusions, hallucinations, disorganized thinking). As many as two-thirds of bipolar patients have a lifetime history of psychosis (Rivas-Vasquez). Bipolar affective disorder is a disturbance of the brain characterized by major mood swings. When the condition is severe, an individual may experience episodes of extreme highs (mania) and extreme lows (depression) several times a year. These episodes may last between a few days to a few months. The DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision) adds the suffix “rapid cycling” to the diagnosis of bipolar disorder if the individual experiences four or more mood episodes (depression, manic, or mixed) during a twelve month period. The suffix “with seasonal pattern” applies to bipolar affective disorder when the depressive component is related to the season of the year (e.g., fall or winter).

In mania, the essential feature is brain overactivity. Thought processes are accelerated, mood is generally elevated, the need for sleep is greatly reduced or absent, and energy seems limitless. Unfortunately, thinking becomes less critical and often illogical. Insight into the condition may be missing entirely as is the ability to discriminate between rational and faulty thinking. Consequently, through impaired judgment, individuals tend to greatly overestimate their abilities, act impulsively, and may completely ignore social conventions and often behave in a grossly inappropriate or outlandish manner. Psychosis may be present with delusions of grandeur such as being the President or Jesus Christ. The periods of depression are also dangerous particularly when they occur in the wake of a manic episode. The frantic energy, racing thoughts, exuberance, and optimism characteristic of mania is suddenly replaced by morbid preoccupation, hopelessness, and apathy.

Bipolar illness presents in many variations both in terms of the severity of mood swings and the rate at which they change. Some individuals with sustained periods of a milder form of mania known as hypomania may productively harness the abundance of energy and ideas in very creative ways. Many of our most

celebrated geniuses in music, literature, theater, science, and politics were probably so “afflicted.” Others may experience long and intense depressions with only fleeting episodes of a near-normal mood in between.

DSM-IV-TR divides bipolar disorder into four categories depending on the particular presentation. Bipolar I disorder is characterized by the occurrence of one or more manic or mixed episodes, and depressive episodes may have occurred. Bipolar II disorder is characterized by the occurrence of major depressive episodes and hypomanic episodes. Cyclothymic disorder features symptoms of hypomania and depression. Bipolar disorder, NOS (not otherwise specified) is applied when symptoms do not clearly fall into any of the above categories.

There is no single proven cause but it is thought to be a biochemical problem related to lack of stability in transmission of nerve impulses in the brain. This biochemical imbalance makes individuals with bipolar affective disorder more vulnerable to emotional or physical stress.

Risk: Bipolar affective disorder can present at virtually any point across the life span. Data from the National Institute of Mental Health Epidemiologic Catchment Area (ECA) study discovered a median age of onset of 18. Bipolar affective disorder is a heritable biologic illness with occurrence higher in relatives of individuals with the condition. The presentation and course of bipolar disorder differs between women and men, depending on the subtype of the condition. The onset of bipolar disorder tends to occur later in women than men, and women more often have a seasonal pattern of the mood disturbance. Women experience depressive episodes, mixed mania, and rapid cycling more often than men (Thase).

Incidence and Prevalence: Estimates of the lifetime prevalence of bipolar affective disorder from two major community surveys of the general population of the US vary from 1.0% to 1.6% of adults (Keck).

Diagnosis

History: The diagnosis can be made based on history or by psychiatric evaluation during a manic phase. During a depressive phase, observation must be augmented by history to differentiate between bipolar and major depressive disorders. Even with a careful history, the diagnosis may prove to be incorrect in two-thirds of individuals and must be considered a working hypothesis.

A good medical history is initially necessary to exclude the use of steroids, thyroid supplements, other prescription medications, or nonprescription “street” drugs such as amphetamines and cocaine.

The DSM-IV-TR spells out specific criteria for the diagnosis of a manic episode. In general, the mood disturbance must cause “marked impairment” in social or occupational functioning and must not be due to a medical condition, effect of a medication, or drug intoxication. Three of the following symptoms must be present for a minimum of 1 week: inflated self-esteem, decreased need for sleep, more talkative than usual, racing thoughts, easily distracted, increased purposeful activity, and excessive involve-

ment in risky endeavors with potential adverse consequences.

There may be a history of conflicts at work; legal, financial and family problems; spending sprees or extravagant purchases; business misadventures; extramarital affairs; impulsive travel; or turbulent social relations. Psychosis may be present with delusions of grandeur such as the individual thinking that he or she is the President or Jesus Christ.

During depressive episodes, the individual has feelings of sadness, hopelessness, and loss of interest in life activities or relationships. These symptoms are present for at least 2 weeks and make it difficult for the individual to function. They are associated with at least four of the following: thoughts of death or suicide, trouble sleeping or sleeping too much, poor appetite or overeating, difficulty concentrating and making decisions, feeling slowed down or too agitated to sit still, feeling worthless or guilty with very low self esteem, and loss of energy or feeling tired all the time. Hearing voices or seeing things that aren't there (auditory or visual hallucinations) or believing things that aren't true (delusions) may accompany severe depressive episodes.

Physical exam: When the illness is first noticed, a thorough exam should be performed to exclude physical causes such as hyperthyroidism or neurological disease. Observation of the individual's orientation, dress, mannerisms, behavior, and content of speech provide essential signs to diagnose the illness. A psychiatric evaluation should be done as soon as possible if a manic episode is suspected.

Tests: Psychological testing such as the Minnesota Multiphasic Personality Inventory (MMPI-2) may aid in diagnosis if the evaluation is made while the individual is in a near-normal mood and the history is merely suggestive of bipolar illness. Laboratory tests should be done to rule out endocrine or metabolic disturbances, or to monitor compliance if medications are already being prescribed. As low blood levels of thyroid hormone are more common in individuals with rapid cycling than in other individuals, thyroid function tests should be done before, during and after treatment as medically indicated. Urine screens for licit and illicit drugs should be done to rule out drugs as factors contributing to the symptom picture.

Treatment

Medications are the mainstay of treatment, with psychotherapy a useful supportive tool. Medications consist primarily of mood stabilizers, such as lithium and valproic acid, that moderate the intensity of mood swings. The most extensively studied mood-stabilizing agent is lithium and often the first choice of treatment for bipolar affective disorder. Anticonvulsant medications, such as valproic acid, lamotrigine, and carbamazepine, have increasingly been employed as important pharmacotherapeutic alternatives, either as a primary pharmacotherapy or as augmentation to lithium. Antipsychotic medications such as olanzapine and clozapine may be used. Recently the FDA has approved risperidone and quetiapine as primary and as adjunct therapies for the treatment of bipolar affective disorder. In August, 2004 the FDA approved ziprasidone for manic and mixed (high and low) episodes.

Unfortunately, many individuals choose not to take the medications as directed and as a result relapse into mania. Noncompliance with medications is sometimes due to unpleasant side effects. In other cases, however, it is clearly a matter of preference. Many bipolar individuals so enjoy the "high" feelings associated with the mania that they do not want to give it up. Because these medications are potentially damaging and prescribed for life, periodic laboratory testing is necessary.

Occasionally, the medications prove to be ineffective in bringing a manic episode under control. In this instance, electroconvulsive therapy (ECT) may control the acute episode, and may also be continued on a regular basis as a preventive measure against future mood swings.

During manic episodes, there is a high-risk of accidental death. Psychiatric hospitalization is frequently necessary to ensure the individual's safety. The periods of depression are also dangerous, particularly when they occur in the wake of a manic episode, and may also require hospitalization. When antidepressants must be used, they should be given with a mood stabilizer to prevent the individual from rebounding into hypomania. As with most serious psychiatric illnesses, there is no cure. Medication-assisted remissions are common, however, and may result in a near normal life.

Pharmacotherapy is the primary treatment for bipolar affective disorder, but many authorities recommend augmentation with various psychotherapeutic techniques. A primary goal of psychotherapy is reducing the high rate of medication discontinuation and overall noncompliance with the pharmacological regime. Other risk factors associated with mood instability also serve as psychotherapy objectives. Psycho-educational classes, support groups, and cognitive behavioral therapy groups lend themselves well to adjunctive treatment of bipolar disorder, and spouse and family involvement can also be helpful. If an individual has a dual diagnosis of mental illness and addiction, integrated dual diagnosis treatment may be helpful. This type of treatment focuses on treating both diagnoses simultaneously by the same clinician or team of clinicians on a personalized basis.

Prognosis

Individual outcomes vary greatly. During manic episodes, there is a high-risk of accidental death. Manic episodes can last anywhere from a few days to several months. With medications, the duration of manic episodes can be shortened significantly but may still involve a month or more of intensive therapy, often on an inpatient basis. Suicide attempts may complicate a depressive episode. Individuals with bipolar affective disorder have at least a 15-fold greater risk of suicide than the general population. Left untreated, the illness becomes worse with time and may end up being very resistant to treatment, rendering the individual incapable of working or having normal relationships.

Bipolar disorder was the sixth leading cause of disability worldwide in 1990 (Keck). Morbidity resulting from the illness is not limited to acute episodes of mania or depression. Full recovery of functioning often lags behind remission of symptoms.

In general, bipolar disorder cannot be cured but the symptoms can usually be controlled. Individuals can frequently lead normal and productive lives. In less fortunate cases, the illness may be nearly impossible to arrest or control and results in permanent total or near-total disability. Early in the course of the disease, spontaneous remissions of up to several years duration are sometimes seen. This “honeymoon period” may delay diagnosis or convince the individual that the diagnosis was incorrect.

Up to 60% of individuals with bipolar disorder obtain some relief from lithium and other mood stabilizers, but the response rate is lower in those with rapid cycling (Hillard).

Differential Diagnoses

- Alcohol/substance abuse
- Impulse control disorder
- Major depressive disorder
- Mood disorder due to a general medical condition
- Personality disorder
- Schizoaffective disorder
- Substance-induced mood disorder

Specialists

- Clinical Psychologist
- Psychiatrist

Comorbid Conditions

- Alcohol and substance abuse disorders
- Anxiety disorders
- Migraine headaches
- Obsessive-compulsive disorder
- Panic disorder

Complications

Complications depend on the severity of the illness and the presence of impaired reality testing (psychosis). The most serious complication is accidental death or suicide. Other consequences of impaired judgment may include conflicts at work; legal, financial and family problems; spending sprees or extravagant purchases; business misadventures; extramarital affairs; impulsive travel; and turbulent social relations. Lifelong substance abuse affects up to 50% of bipolar individuals and may interfere with treatment (Tennen).

Factors Influencing Duration

A history of episodes of relatively short duration, good response to medications, and long periods of normal mood predict the shortest period of disability. Substance abuse, noncompliance with medications, psychosis, and a history of lengthy hospitalizations tend to delay recovery. Serious episodes of mania may take 1 to 2 months and occasionally longer to be controlled sufficiently to allow return to work. Some individuals may be unable to maintain stable employment largely because of substance abuse or problems getting along with others.

Length of Disability

Psychotherapy and pharmacotherapy, bipolar affective disorder.

DURATION IN DAYS			
Job Classification	Minimum	Optimum	Maximum
Any Work	7	28	56

Return to Work

Accommodations depend on the type of work required. Stressful events and/or lack of sleep may increase risk of igniting a manic episode. Rotating shifts should be avoided. Regular daytime hours may be necessary for significant periods of time. High-pressure jobs or jobs with deadlines requiring the individual to work extremely long hours over extended time periods are also not recommended. Leaves of absence may be necessary periodically.

Failure to Recover

Regarding diagnosis:

- Was diagnosis confirmed? Based on what criteria?
- Even if a clear history of bipolar illness is present, have the history, physical exam, and testing excluded other possible causes of symptoms?
- Does medication and drug history reveal use of steroids, thyroid supplements, other prescription medications, or street drugs that could cause similar symptoms?
- Is there evidence of rapid cycling (defined as four or more episodes of mania, excitement with moderate behavior change, or depression in any 12-month period)? Because it responds poorly to treatment, could failure to improve be linked to rapid cycling?
- Because low blood levels of thyroid hormone are more common in individuals with rapid cycling than in other bipolar individuals, were thyroid function tests performed before and during treatment?
- Is there a history or evidence of current substance abuse that makes an individual more prone to cycling with shorter episodes than usual?

Regarding treatment:

- Does individual fit criteria for rapid cycling?
- Is thyroid replacement therapy warranted based on thyroid function tests?
- Has use of antidepressants precipitated hypomania, warranting discontinuation or change in medications?
- Is there current evidence of substance abuse? How successfully is the substance abuse being addressed?
- What plan is in place to ensure compliance with medication regime?
- If combinations of medications and psychotherapy have not provided adequate relief, is electroconvulsive therapy (ECT) warranted at this time?
- If self-harm or personal neglect put individual at risk, is psychiatric hospitalization warranted?

Regarding prognosis:

- Does individual display any tendency toward self-harm or suicide? What preventive safeguards are in place?
- Is illness interfering with self-esteem, friendships, social supports, and career goal achievements?
- Would individual benefit from one-on-one psychotherapy based on interpersonal, cognitive, or behavioral approaches?
- Is individual involved in a support group?

- If no improvement occurs after 6 to 8 weeks or if symptoms have worsened, is it time to try another treatment approach or another medication? Get a second opinion from another health care professional?

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