QUESTION-AND-ANSWER SESSION

Q: How can clinicians better distinguish anxious from agitated depression in patients with bipolar disorder?

Dr. Goldberg: When a clinician finds signs of agitation or anxiety in a patient with a mood disorder, which is a common presentation, the question becomes is this psychomotor acceleration from mania or does this presentation stem from anxiety? When there are overlapping symptoms that are nonspecific, one has to be guided by corroborative signs. This means if a patient, in addition to the manifestations of anxiety or agitation for example, is also having a decreased need for sleep or fast thinking. Fast thinking refers to if the content of the patient's thinking is more a rapidity from one thought to the next rather than a ruminative brooding preoccupation over an overvalued thought. The clinician should look for the nonoverlapping features to make that distinction. This is very difficult to do in a cross-sectional approach and in isolation of other features. Also, many of the medications used are nonspecific. Some of our antimanic drugs can have anxiolytic properties. Thus, a clinician cannot say that if a patient takes any typical antipsychotic and they get better, the condition must have been mania; symptoms could have been caused by the anxiolytic effect of the antimanic drug. However, if there a pervasive disturbance not just in mood or anxiety, but also the sleep/wake cycle, behavior, cognition, speech, and language, among other domains, then the clinician should be interested in the movement of multiple symptoms as an array rather than any one solitary symptom.

Q: Are there any keys to the structuring applied to the differential diagnosis of bipolar disorder beyond the strictly narrowly defined limitations of the Diagnostic and Statistical Manual of Mental Disorders? Also, how is structure related to treatment?

Dr. Reilly-Harrington: Diagnosis is a very difficult area, particularly as clinicians work to impose structure on behaviors that often are erratic and challenging as well as reported retrospectively. Diagnosis is a challenge. The assessment and diagnosis of bipolar disorder is the piecing together of a retrospective history and trying to discern whether the structure clinicians impose in terms of number of symptoms to qualify the manic versus hypomanic episode or amount of impairment, for example, is effective. Regarding the structure of cognitive-behavioral therapy, anything that clinicians can do to provide tools for these patients to have more structure in their lives is very important. Often these patients' lives are so erratic and chaotic that even the structure of coming to a clinic for treatment and having that structure of meeting with a team of professionals who care about them in a supportive environment is quite helpful. I particularly think that this is an issue that applies to bipolar disorder across the life cycle. The case that I mentioned of a college student with bipolar disorder is a very tough time of life for patients with this illness because many people in their late teens and early 20s are enjoying a lack of structure in their lives. Staying out late and being able to have a free and easy lifestyle is a recipe for disaster for many patients with bipolar disorder. In my experience, the more structure and discipline a person can add to their lifestyle at any age is beneficial. Even professionals may need to decrease their amount of overseas travel; I have seen many executives in my practice who have had to abandon traveling to Asia because that historically has led to episodes. Overall, any kind of structure that works for the patient is very important to support.

Dr. Bowden: Treatment should involve people other than a single professional working with a single patient. There should be not only a collaboration across a group of professionals, but also with family members and others who are engaged with these individuals.

Dr. Goldberg: When clinicians conduct initial evaluations, and particularly if they are meeting with collateral historians, assessment does afford a chance to gauge not only symptoms in the here and now and historically, but also factors like whether there is much expressed emotion in the family, hovering, and a negative critical communication style that may subvert or undermine an otherwise therapeutic regimen. This kind of culture for the patient may prompt the clinician to think about whether a cognitively oriented psychotherapy may have some specificity for the types of symptoms that are present. Research has yet to define if one type of structured psychotherapy is more beneficial than another (eg, cognitive vs interpersonal vs family-focused). However, in evaluations with the patient, the clinician hopefully acquires some sense as to what the operative psychosocial problems may be for their patient.

Dr. Reilly-Harrington: For those who work in the field of psychosocial treatments for bipolar disorder, that is a next step in terms of comparative receptiveness; matching what types of treatments work best for which patients. However, being aware of the patient's issues in an evaluation is very important in terms of trying to ascertain what types of treatments will be most useful, where the patient's weaknesses are, or problems in either the family system or the patient's own thinking or acceptance of the illness. Stigma is very important as well. It is often important to have the patient's support system recognize true information about the illness. Many families discourage the use of ongoing medication because they are concerned about certain side effects they have learned about. For example, lithium often scares family members. Thus, education is very important not only for the patient, but the family and support system as well.