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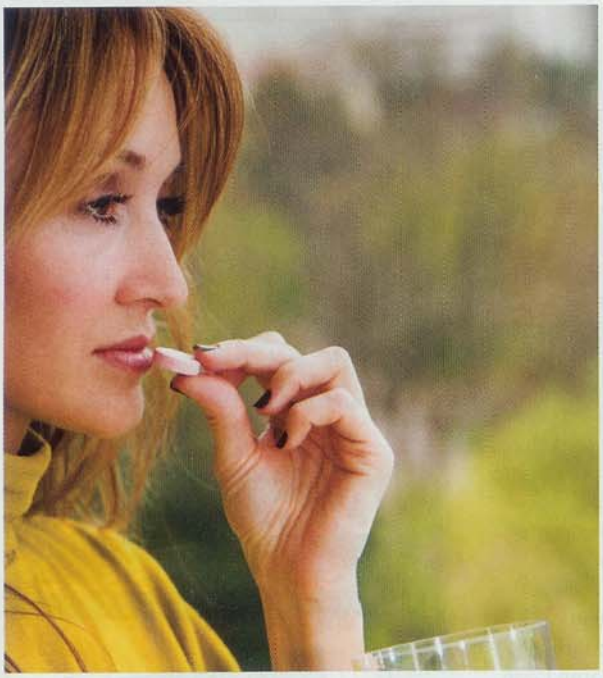

MEDICATIONS FOR BIPOLAR DISORDER

By Joseph Wegmann, PD, LCSW

While recently presenting a seminar on psychopharmacology, I was asked a question I'd never before encountered, even after teaching the same material to more than 10,000 clinicians in 46 states. The seminar had just completed a discussion of bipolar disorder and its medication management when a social worker in the audience asked, "Do you believe that the pharmacological treatment of bipolar disorder is a mess?"

After a bit of hesitation, I answered "Yes." After all, the social worker had posed succinctly a question I had been asking myself for some time. And, to say the least, the medication management of bipolar disorder is all over the place—clinicians reliably agree on only a few treatment protocols.

Challenges

One reason for this seeming chaos, as well as a major challenge in diagnosing bipolar disorder, is that the disorder itself is a moving target. That is, there is considerable variability in the disorder's course from client to client.

We typically think of bipolar disorder as a cyclic process of mood, behavior, and thought processes, one that fluctuates between mania (or hypomania) and depression. But in fact, the disorder's natural course is both episodic and recurrent. Bipolar disorder can initially present with one or more episodes of depression before the first manic or hypomanic episode even occurs. As much as one third of the life of an individual with bipolar disorder is spent under the ominous cloud of a serious depression.

There are other challenges, too. For one, it can be difficult to distinguish among the three types of bipolar presentations: bipolar I, bipolar II, and cyclothymia. For another, diagnosis is further complicated when it involves a "rapid cycler," a person who experiences at least four episodes—manic, depressive, hypomanic, mixed—within a 12-month period.

Medication Options

Lithium was the first mood-stabilizing medication approved by the FDA for the treatment of acute mania and hypomania. Lithium not only treats classic mania but is also effective in the management of bipolar depression and the prevention of relapses. But this medication's "gold standard" properties are offset by its slow onset of action, stringent requirements for blood level monitoring, and toxicity profile. As a result, many clinicians in the United States have migrated to the use of antiepileptic drugs, with Depakote supplanting lithium as the first-line agent in the treatment of mania, although the rationale for this switch lacks firm scientific footing. Studies are inconclusive regarding the efficacy of Depakote in the management of bipolar depression.

Another antiepileptic medication, Tegretol, is effective in treating mania, but like Depakote, it is unproven in treating bipolar depression. Other antiepileptics, including Lamictal, Neurontin, Topamax, and Trileptal, have demonstrated little or no effectiveness in treating bipolar mania, although Lamictal has been shown to reduce the risk of future bipolar depression.

All the first-generation antipsychotics, including Thorazine, Prolixin, Trilafon, and Haldol, have been FDA approved for mania. The second-generation agents Risperdal, Zyprexa, Seroquel, Geodon, and Abilify are also FDA approved for mania. In addition, Zyprexa and Seroquel have shown some effectiveness in treating bipolar depression.

Whether second-generation antipsychotics have mood-stabilizing properties has become a hotly debated issue. If they do, it is unclear how they are distinct from one another or what advantages they offer over lithium and anticonvulsants.

Youth Debate

When it comes to stabilizing and maintaining remission of the constellation of symptoms associated with bipolar disorder, clinicians often disagree about an appropriate course of action. This is particularly true in regard to yet another controversial challenge: the use of mood stabilizers and antipsychotics in the treatment of pediatric bipolar disorder, especially among young children.

There's little doubt that childhood bipolar disorder is being diagnosed more frequently than in the past. An article in the September 2007 issue of the *Archives of General Psychiatry* showed that office visits by children diagnosed with bipolar disorder increased significantly during the 10-year period between 1994 and 2003. However, disagreements abound as to what this means. Some researchers view the trend as a sign of progress: A disorder that has long gone undiagnosed in this population group is now being better screened and treated. Others, however, are more skeptical; they perceive the trend to be an example of gross overdiagnosis.

In truth, bipolar disorder is quite difficult to diagnose in children. Many of the disorder's characteristic symptoms overlap with symptoms of other disorders, particularly attention-deficit/hyperactivity disorder (ADHD) and conduct disorder. In fact, studies indicate that 40% to 90% of children with bipolar disorder also have ADHD and that roughly 50% of children with bipolar disorder also have comorbid conduct disorder. What's more, the presentation of childhood mania differs dramatically from that in adults. Children and adolescents in the manic phase of the disorder tend toward extreme irritability and destructive outbursts as opposed to the grandiosity or euphoria more common among adults. Also, the duration of these episodes in children is often too brief to satisfy diagnostic criteria.

When treating children and adolescents diagnosed with bipolar disorder, the most widely used mood stabilizers are lithium and Depakote. Although studies confirm the effectiveness of these medications, their safety is questionable due to the lifelong nature of bipolar disorder. Long-term lithium use has been linked to quite a few side effects, ranging from acne and cloudy thinking to weight gain, tremors, decreased thyroid function, and kidney problems. As a result, children taking lithium should have blood level monitoring several times each year. Similarly, Depakote requires blood testing every three to six months to monitor for possible liver problems and toxicity. These potential health risks have led the FDA to order the placing of a "black box" warning on Depakote for both pancreatitis and liver failure.

Second-generation antipsychotics appear to be effective for managing the severe mood swings associated with bipolar disorder in children and teens. But again, benefit vs. risk is a considerable concern. These drugs are apt to induce weight gain, sleepiness, Parkinsonian and extrapyramidal symptoms, elevated lipid levels, and an increased risk of developing type 2 diabetes. As a result, only two antipsychotics—Risperdal and Abilify—are now approved for use in children. Three others—Seroquel, Geodon, and Zyprexa—are under the FDA's consideration for use with children.

The Social Work Perspective

While most social workers lack formal medical training and don't prescribe medications, they are nevertheless often responsible for clients utilizing medications for bipolar disorder. Social workers' role in supporting this treatment modality cannot be overestimated.

At times, social workers collaborate closely with the prescriber, offering recommendations and helping monitor a client's medication use. Other times, social workers help improve compliance by identifying the reasons for nonadherence, as well as by helping identify side effects and other adverse events. By expanding their knowledge of psychotropic medications, social workers can become more proficient in a client's overall treatment. They can also gain additional respect within the patient care delivery system.

— Joseph Wegmann, PD, LCSW, is a licensed pharmacist and clinical social worker with more than 30 years of experience in the area of psychotropic medication. He maintains an active psychotherapy practice specializing in the treatment of depression and anxiety.

Read "Reaching Out to Children of Parents With Mental Illness" at www.SocialWorkToday.com. Click on Mental Illness.