Viewpoint: Bipolar disorder isn't the same for everyone, so people should have more say in how they're treated

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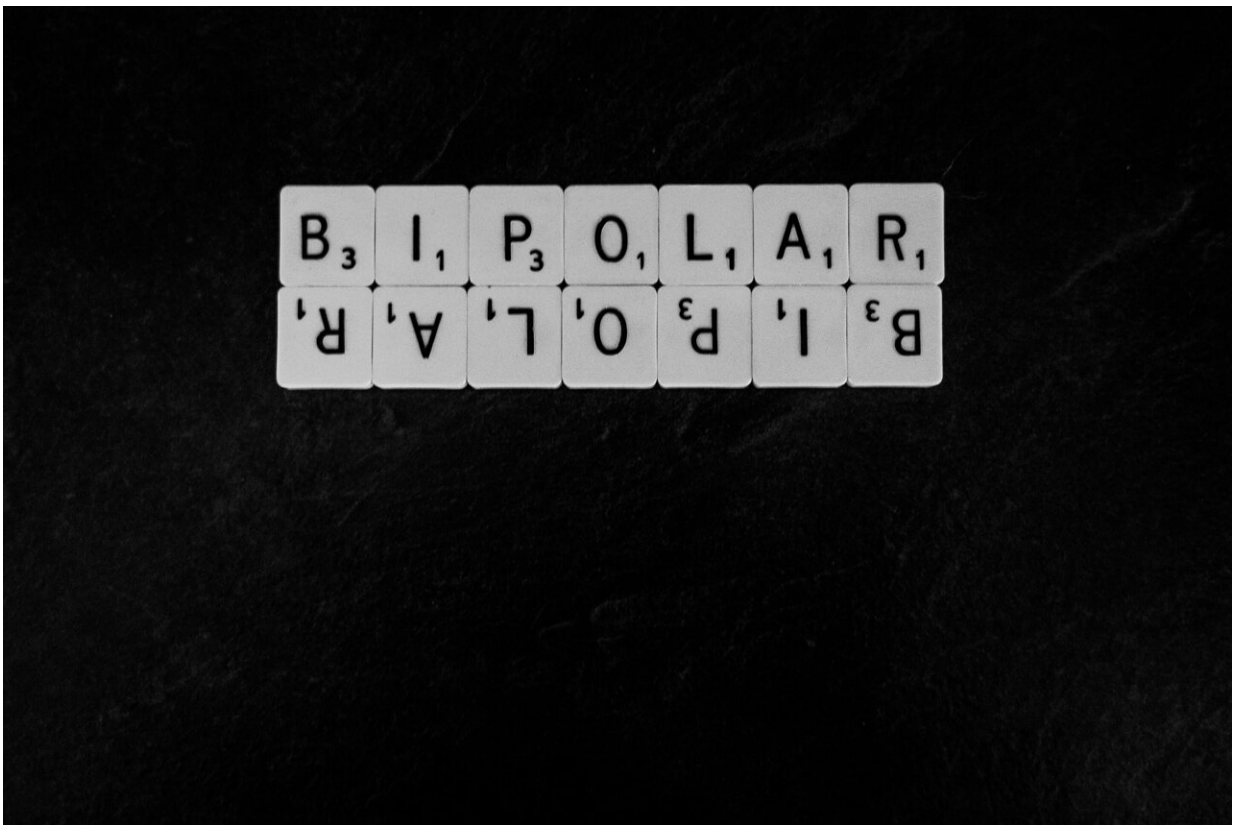

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Imagine you, or someone you know, is diagnosed with bipolar disorder. One drug is prescribed, but you have heard another drug is better. What

are your next steps? Do you seek evidence? And if so, what type of evidence would you consider?

Around 2% of the adult population have a bipolar disorder. It can create high levels of suffering, carry suicide risks, and persist for decades. Management options vary, and if you search for information online, it's easy to become overwhelmed by the many different views and interpretations of "the evidence" obtained from clinical trials.

Some medications can be extremely helpful for stabilizing mood, but they can often have side effects. Certain medications may be more beneficial for certain types of bipolar disorder, but how do you know which "type" you or a loved one has?

Clinical specialists, including psychiatrists, often rely on guidelines authored by professional organizations to evaluate the evidence for treatments. However, there is minimal agreement between many of the current guidelines. A new approach is needed that places emphasis on "real-world" effectiveness and respects the observations of people with bipolar disorder.

Two types of bipolar disorder

As far back as Hippocrates, bipolar disorder has been known to the medical community. Originally called "manic-depressive psychosis", it is now known as bipolar I disorder. In the mid-1990s, bipolar II disorder was defined. Although this second "sibling" has always existed, it was previously viewed as more of a personality style, and frequently given the label of "cyclothymia".

Both bipolar I and bipolar II are marked by pronounced mood swings. During "highs", individuals feel energized and "wired". They talk more, spend more, and require less sleep but don't feel tired. They might

experience a heightened sex drive, feel more creative, or so "bulletproof" they take more risks. Anxiety seems to melt away.

During "lows", depression rolls in like a fog. Sufferers may lie in bed for days, lacking any energy. They can't derive any pleasure in life. Cheerless and battling impaired cognitive capacity, they can be at greater risk of suicide.

The key distinguishing feature between the two bipolar conditions is the presence of psychotic features (delusions and/or hallucinations) in those with bipolar I.

Current treatments

Medication is the main way bipolar disorders are managed.

Melbourne psychiatrist John Cade discovered the effectiveness of lithium as a treatment for manic depression in 1949. This landmark research ushered in the era of condition-specific psychopharmacology.

Psychiatry can proudly claim its status as an evidence-based discipline. Practitioners refer to research-based guidelines to determine the best medications to help stabilize a bipolar disorder. Options now include lithium, three anti-epileptic drugs, multiple antipsychotic drugs and antidepressants. While most guidelines rate lithium highly for both bipolar types, we personally favor lithium as the first choice medication only for bipolar I, and the anti-seizure drug lamotrigine for bipolar II.

But evidence isn't everything

In 2017, our research group examined 11 guidelines published by professional organizations. All were "evidence-based", but we found

minimal agreement between them, thus raising questions about their validity. New guidelines have been published since then but the trend for minimal agreement continues.

Assessing a psychiatric evidence base is difficult. For medical trials, the treatment being tested is compared against a treatment in common use, and/or against a placebo. Results from multiple trials are aggregated to compare their overall impact.

But the way study participants are selected to participate in trials presents a problem. Recruitment is generally limited to those with milder conditions, those without co-existing disorders, or those taking limited medications. Participants might also sign up to obtain medication at no cost, which may affect their motivation and reporting. Finally, the observations made by managing doctors commonly differ from those made by the patients about the benefits and side effect impact of the drugs given.

So there is a strong argument for the need for "real-world" studies prioritizing the views of patients with a bipolar disorder, instead of judging drugs via clinical trials and external raters.

Accounting for side effects

In addition to evaluating the effectiveness of any drug, we need to assess the side-effects. For instance, lithium can be the right medication for some with a bipolar disorder and, as noted, it is the most frequently recommended medication across clinical guidelines. However, it has multiple side effects.

Our 2021 efficacy study compared lithium and lamotrigine in a small sample of patients with bipolar II. For the 28 patients who completed the study, the benefits were similar for the two medications. But 50% of the

completers receiving lithium experienced distinctive cognitive impairment—side effects that affected their thinking and reasoning.

This is of particular concern because bipolar disorders are known to be over-represented in creative people and high achievers. We suspect, from clinical observation, that lithium is not the best option for bipolar II, and the first author has long observed it is more cognitively "toxic" for those individuals with a bipolar II condition.

Many of the antipsychotic drugs nominated in guidelines also have major side effects, including weight gain and diabetes. People who are stable while taking these medications without major side effects should not be alarmed. But these risks support a push for more tailored treatments based on real-life costs and benefits, informed by people's experiences.

We want to hear from people with bipolar disorders

All these concerns highlight the need for research focused on "real-world" samples to determine the best treatments that consider each person's responses to any medication. We are conducting such a study now, in collaboration with the Black Dog Institute. If you are interested, you can access the study here.

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