Time to inform minds about the disabling impact of bipolar disorder

AGENDA

A column for outside contributors.
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In recent years the term “bipolar” has crept into everyday language. Teenagers use it to describe friends who are over-emotional or melodramatic, for instance. In the United States, there is a vogue for describing individuals with energetic personalities as being “bipolar lite”. Part of this is related to a higher profile for bipolar disorder, driven by people including Stephen Fry, Frank Bruno and Catherine Zeta-Jones going public with their diagnosis. Although these disclosures are welcome, they also carry a risk of trivialising what, for many people, remains a severe, enduring and, at times, life-threatening illness.

Bipolar disorder can be a highly disabling and recurrent psychiatric disorder, characterised by episodes of severe depression and mania, that, for many people, has a devastating impact on their relationships, their ability to work and ultimately on their longevity. About one person in 10 with bipolar disorder will die by suicide and people with the diagnosis have a life expectancy reduced by about 15 years. Most premature mortality is driven by cardiovascular diseases that are under-diagnosed and under-treated. As part of its Changing Minds season, BBC Radio Scotland aired an episode of the science series Brainwaves dedicated to bipolar disorder, that sensitively highlighted this as a relatively common, highly complex and poorly understood condition. Such programmes are a positive development, not least because services for people with bipolar disorder in Scotland (and the rest of the UK) probably lose out, in term of resource allocation, to other important conditions such as schizophrenia.

To some extent, this might be because bipolar disorder is misperceived as a mild temperamental difficulty rather than a serious mental illness. It can struggle to secure the funding to deliver a range of effective evidence-based treatments, including medications (such as lithium) and psychological treatments (such as group psycho-education).

But the boundaries of bipolar disorder are poorly defined in clinical practice. About 1% of the population is affected by classic bipolar I disorder and a further 1%-2% are affected by bipolar II disorder. The difference between the two is that individuals with bipolar I experience severe episodes of mania (often with psychosis) whereas those with bipolar II disorder tend to experience milder episodes of mania, known as “hypomania”. However, both forms of the disorder are disabling as they are associated with recurrent episodes of major depression and life-long problems with anxiety, panic attacks and drug or alcohol misuse.

In the psychiatric profession, there has been a debate about where we should draw the line between bipolar disorder and the normal experience of “highs and lows”. One of the consequences of a disorder increasingly featured in the media (for example, during the EastEnders storyline that explored Stacey Slater’s experience of bipolar disorder) is that more people with mild and self-limiting difficulties will go to their GP thinking they might have bipolar disorder. In turn, this has led to an increase in referral rates to psychiatrists and, in some (but not all) parts of the UK, a tightening of the criteria by which services will assess and treat individuals.

This has left many people with bipolar II disorder being looked after exclusively by their GPs without access to local specialist expertise and evidence-based treatments that could significantly impact on their long-term outcome.

Although the public profile of bipolar disorder has improved in recent years, it remains a serious and poorly understood condition that requires specialist psychiatric expertise.

It is clearly important that we strike a balance between raising awareness and campaigning for better services while avoiding misrepresenting the condition as nothing more than a feature of famous personalities, emotional teenagers and even weather systems or money markets.

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