Risk assessment and management in bipolar disorders

Darryl L Bassett

Bipolar affective disorders carry significant risks which need to be addressed; these risks and approaches that can be applied to help manage them are outlined here.[1-3]

ABSTRACT

- Bipolar affective disorders carry significant risks to the patient and sometimes others.
- The form of the illness relapse needs to be determined, and high-risk features such as psychosis and suicide considered.
- Gathering collateral information from others is invaluable.
- Mania brings particular risks of disinhibition, poor judgement, risk taking and sometimes aggression.
- Depression carries notable risks of suicidal behaviour, poor self-care and homicide.
- Both mania and depression bring risks of substance misuse and disrupted relationships.
- Management requires an optimal therapeutic alliance with good communication, appropriate treatment and sometimes compulsory care during crises.
- Preventive strategies are invaluable.

MJA 2010; 193: S21–S23

Risk assessment

Fundamental clinical approach to risk assessment

At the outset, it is important for the clinician to clarify the nature of the presenting problem and determine the current form of the disorder: mania, depression, or combined mania and depression (known as a mixed state or "dysphoric mania"). Mixed states may be overlooked as bipolar phenomena because the predominant affect may be irritability, rather than euphoria. Further, it is helpful to assess whether the patient has psychotic symptoms and, in particular, to establish whether these might be a signal of high risk (eg, if, during mania, patients believe they can fly or, during depression, patients hear voices saying they should kill themselves because they are evil). It is also critical to ask about suicidal and homicidal thoughts, beliefs and plans. At the same time, the patient should be assessed for the capacity for judgement and decision making.

Information from other significant sources may be particularly helpful in establishing risk. For example:

- Family members are an invaluable source of information, and are often more useful for determining risk in an acute situation than the mental status examination of a patient.
- Close friends are frequently willing and able to provide valuable information.
- Often a patient will be well known to colleagues who can help in acute assessment.
- In some situations, particularly serious crises, unrelated observers may be able to help.

Risks associated with mania

The manic state carries a particular set of potential risks, which can be summarised as follows:

- Heightened risk-taking behaviour which follows a belief of being invulnerable. This may include erratic or high-speed use of a vehicle, crossing roads without due care, swimming in unsafe situations or attempting to fly by jumping from a high place.
- Excessive spending of substantial sums of money or inappropriate generosity. The direct financial impact of such behaviour can be severe, and the indirect effect on credit ratings can be significant.
- Excessive use of alcohol or other psychoactive substances.
- High levels of irritability and aggression with risks to self or others, particularly if the patient is opposed in their intentions. This is especially evident in mixed states, where heightened energy combines with dysphoric mood to produce a potentially explosive mixture.
- Disinhibited behaviour such as uncharacteristic sexual behaviour (promiscuity, unprotected sex, socially inappropriate propositions, exhibitionism) or other socially inappropriate behaviour. This can be particularly damaging in the workplace and in personal relationships, and potentially damaging to health.
- Socially disruptive behaviour derived from grandiosity, such as trying to take over piloting an aircraft that is in flight or inappropriately approaching a political leader.
- Excessive and personally offensive sarcasm and rudeness that can damage interpersonal relationships.

Risks associated with the depressed phase

The depressed phase of bipolar disorder is associated with a different set of risks, which include:

- Self-injury, including suicide. Patients with type II bipolar disorders appear to commit suicide more often than those with type I bipolar disorders (24% v 17%) and those with bipolar disorders do so more than those with unipolar depression (12%).[4]
- Poor self-care, including inadequate diet, poor hygiene and poor adherence to medical treatments.
- Disruption of employment and close relationships with potentially serious negative consequences.
- Substance misuse.
- Rarely, psychotic depression is accompanied by fears that significant others will be subjected to a terrible fate, and the patient feels obliged to "save" them from this experience. Homicide may follow. This risk is particularly significant in postpartum depression.

Assessment of the risk of self-injury, including suicide

Self-injury, including suicide, can occur in both manic and depressed phases of bipolar disorder, although it is much more common in depression. In mania, the risks are generally related to heightened risk-taking behaviour, but periods of severe depression can arise during a manic episode (ie, mania may develop into a mixed state) and carry risk of self-injury or injury to others. Factors that are associated with increased risk of suicide in patients with bipolar disorder can be divided into static and dynamic

1 Factors associated with increased suicide risk in patients with bipolar disorder[5]

Static factors

- Recent bereavement or divorce
- The 12 months after childbirth
- Late adolescence, early adulthood or advanced age (notably over 70 years)
- Family history of suicide, particularly first-degree relatives
- Social isolation
- Unemployment
- Certain professions (eg, dentists, anaesthetists and psychiatrists)

Dynamic factors

- Severity of the disorder, particularly the presence of psychosis
- Previous profile of the bipolar illness, including rapid deterioration into severe illness episodes
- Past history of self-destructive behaviour, particularly suicide attempts
- Evidence of detailed plans for suicide, notably with physical preparations (eg, hoarding tablets, buying hosepipe or rope)
- Comorbid disorders such as severe anxiety disorders (particularly post-traumatic stress disorder), substance misuse, acquired brain injury or chronic pain
- Personality factors including impulsivity, low frustration tolerance and severe difficulty with attachment to others
- Ready access to a means of suicide such as firearms (mainly a risk for impulsive suicidal behaviour)
- Prominent thoughts of guilt or self-blame associated with depression (particularly delusional guilt)
- Increasingly severe agitation ◆

2 Questions to ask regarding suicide risk[5]

- Do you ever feel like giving up?
- Do your symptoms ever become too much for you?
- Do you ever think that you will not get better?
- How does the future look for you?
- Do you ever think about suicide?
- Would you tell me if you thought about suicide?
- What stops you from committing suicide?
- Do you know anyone who has committed suicide?
- Have you thought of joining someone close to you who has died? ◆

3 Guidelines for managing suicidality[5]

- Offer understanding of the patient's thoughts of desperation and hopelessness
- Offer unequivocal confidence that the patient's distress can be relieved and that a worthwhile future will follow; hope is your best therapeutic weapon
- Ask the patient what is keeping him or her alive, despite his or her despair, and emphasise the importance of these motivations (eg, commitment to family members)
- Emphasise the distress that significant others will experience if the patient commits suicide (ie, that the patient will be missed and his or her emotional pain will be passed on to those who care about him or her)
- Ask the patient to make a commitment to stay alive until you can meet again, even if he or she is in hospital, while you introduce treatments which will help, and give the patient a definite time and date for his or her next consultation
- Try to ensure that the patient is not left alone — observation does not keep people alive, personal contact does ◆

factors; these are summarised in Box 1. Questions about suicidal thoughts that the clinician should consider asking the patient are shown in Box 2.

Risk management

Fundamental clinical approach to risk management

Communication is the key intervention for managing risk. The clinician should advise the patient (and significant others, as appropriate) of the nature of the problem, and emphasise the level of concern. The clinician should also express confidence in being able to help and, where feasible, agree to a mutually satisfactory risk-management plan. Specific treatment interventions, such as medications, are fundamental. Appropriate authorities should be notified of risk, as should those directly involved in the risk if it includes others. This is essential if the patient has specifically divulged homicidal plans. If the patient is suicidal, the guidelines provided in Box 3 should be considered.

It is appropriate to explore simple measures of risk reduction such as asking a spouse to take charge of the patient's credit card, to remove the risk of overspending during mania, and removing access to easy means of suicide (notably firearms and potentially lethal medications). For many patients there will be a history of previous illness episodes, and patients can be encouraged to take their own protective strategies. For example, patients may arrange for access to money to be voluntarily restricted or for medication supplies to be kept in a secure place. They should be encouraged to determine the "personal signature" of their early signs of relapse, so that help can be sought before risks become significant.

During instances of homicidal thoughts and impulses, close support and supervision is essential. Treatment in hospital is usually most appropriate.

In either phase of bipolar illness, concerted treatment is required, with regular review. The patient and significant others need to know how to access help in an emergency. Referral to a public mental health service or private psychiatrist may often be appropriate.

Hospital treatment is appropriate if the risk is high or if psychosocial supports are suboptimal. Compulsory hospital treatment might be required if the risk to self or others is high, if insight and judgement are poor, or if adherence to treatment is inadequate. If compulsory hospitalisation is required, the appropriate forms defined by the local Mental Health Act will be required and contact should be made with a hospital recognised under that Act. Police and ambulance services may also need to be involved. After the patient has recovered sufficiently from an episode which required compulsory treatment, it is good practice to arrange an opportunity to discuss and review — with both the patient and his or her family — the need for compulsory treatment and its impact.

Conclusions

Bipolar affective disorders carry significant risks for patients and those around them. These risks must be kept in mind and addressed conscientiously.

Competing interests

I have received fees from Pfizer and AstraZeneca for advisory board membership, from MDA National for consultancy, from the Medical Board of Western Australia and various legal firms in WA for expert testimony, honoraria from Pfizer, Wyeth, Eli Lilly, AstraZeneca, Servier and Janssen-Cilag, fees from Pfizer for development of educational presentations, funding for travel and accommodation from Pfizer, Wyeth, Eli Lilly, Servier and AstraZeneca, and lecture fees from the Churchill Clinic. I have also received royalties from several books.

Author details

Darryl L Bassett, MB BS, FRANZCP, DipPsychother, Psychiatrist
Hollywood Specialist Centre, Perth, WA.
Correspondence: dbassett@iinet.net.au

References

1 Goodwin F, Jamison K. Manic-depressive illness. Bipolar disorders and recurrent depression. New York: Oxford University Press, 2007.
2 Joyce P, Mitchell P, editors. Mood disorders: recognition and treatment. Sydney: University of New South Wales Press, 2004.
3 Petit J. Management of the acutely violent patient. *Psychiatr Clin North Am* 2005; 28: 701-712.
4 Rihmer Z, Pestality P. Bipolar II disorder and suicidal behaviour. *Psychiatr Clin North Am* 1999; 22: 667-673.
5 Castle D, Bassett D. A primer of clinical psychiatry. Sydney: Churchill Livingstone, 2009.

(Received 8 Feb 2010, accepted 18 Apr 2010) ❑