Who Receives Guideline-Based Pharmacotherapy for Bipolar Depression?

Several organizations have developed guidelines to assist with the treatment of patients with bipolar disorder (eg, The American Psychiatric Association [APA], The Canadian Network for Mood and Anxiety Treatments [CANMAT], The Texas Medical Algorithm Project [TMAP], and the National Institute for Health and Clinical Excellence [NICE]); however, there is not much in the literature about how these guidelines are implemented in clinical practice.

Megan Jo Ehret, PharmD, BCPP, University of Connecticut, Storrs, CT, presented the results of a study that was conducted to identify the demographic and clinical features that are associated with receiving guideline-based pharmacotherapy for bipolar depression in routine clinical care. The study sample comprised 281 inpatients aged 18 to 59 years (73.3% white; 63.7% women) who were discharged from a single facility between January 1, 2005 and December 31, 2007. All patients had a primary clinical diagnosis of bipolar 1 disorder, with the most recent episode being depression. Patients with dementia were excluded. For patients who had more than 1 admission, data from the first admission were used.

Discharge treatment medications were classified by treatment level, based on a consensus of existing guidelines (Table 1).

Table 1. Discharge Treatment Level Classifications.

Level 1	MS with/without an atypical antipsychotic and/or with/without an antidepressant
Level 2	MS + >1 antipsychotic MS + a typical antipsychotic MS + >1 antidepressant >2 MSs
Level 3	MS + topiramate or gabapentin MS, but >4 psychotropics atypical antipsychotic but no MS electroconvulsive therapy only
Level 4	None of the above

Mood stabilizers (MSs) were lithium, lamotrigine, divalproex, carbamazepine, and oxcarbazepine.

In this study, most discharged patients were prescribed 2 to 4 medications. Approximately 83% of patients were discharged on mood stabilizers (MSs) (198 with 1 MS, 33 with 2 MSs, and 1 patient with 3 traditional MSs; 49 were discharged without a MS). The most common MSs that were prescribed at discharge were divalproex (~90 patients) and lithium (~80 patients). A total of 225 (80%) patients were discharged on antidepressants, the majority of which was a selective serotonin reuptake inhibitor (SSRI). The majority of patients who were discharged on an antipsychotic was prescribed quetiapine (n=~100 patients); 33 patients were discharged on an atypical antipsychotic without a MS.

Patients with psychotic features were significantly ($p<0.001$) more likely to be prescribed atypical antipsychotics than those without psychotic features (OR 4.0; 95% CI, 2.0 to 8.3). African-American patients were more likely to receive atypical antipsychotics compared with other races, but the difference was not significant (OR 3.1; 95% CI, 1.0 to 9.2; p=NS). Women were significantly (p=0.004) less likely to receive a MS than men (77.7% vs 91.2%; OR 0.3; 95% CI, 0.2 to 0.7) but were slightly more likely to receive an atypical antipsychotic in the absence of a mood stabilizer (15.6% vs 4.9%; OR 3.6; 95% CI, 1.3 to 9.6; p=NS).

Patients with psychotic features (29.1% vs 12.3% for those without psychotic features; OR 3.5; 95% CI, 1.8 to 7.0) and patients with borderline personality disorder (35.9% vs 12.0%; OR 4.5; 95% CI, 2.2 to 9.0; $p<0.001$) were significantly ($p<0.001$) more likely to be discharged with

≥4 psychotropic medications. African-Americans were significantly (p=0.020) less likely to be discharged with ≥4 psychotropic medications (3.0% vs 19.4% for all other races; OR 0.1; 95% CI, 0.01 to 1.0).

"The patients most at risk for not receiving guideline-based treatment in this study," said Dr. Ehret, "were women and patients with psychotic features or borderline personality disorder."

The overall results of this study were mixed when compared with other studies that examined concordance with guideline-based therapy, in that the rate of compliance was higher than that seen by Lim and colleagues [Lim PZ et al. *Bipolar Disord* 2001] but less than what was reported from the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BP) trial [Dennehy EB et al. *Psychopharmacol Bull* 2007]. This may be attributed to differences in study design as well as the population that was studied.

Personality Disorder: Toward DSM-V

A significant change to DSM-V that is being considered is the use of a dimensional, instead of a categorical, approach to the diagnosis of mental disorders. The research agenda for personality disorders in DSM-V can be considered a test case for such a change. Andrew E. Skodol, MD, University of Arizona College of Medicine, Tucson, AZ, and Chair of the DSM-V Personality Disorders Work Group, provided a glimpse into the group's current thinking.

In considering dimensional approaches to psychiatric illnesses, personality disorder was identified as a good starting point, because it is an area in which both researchers and clinicians have been most dissatisfied with the current categorical approach to diagnosis. The Personality and Personality Disorders Work Group is currently working on a 5-part model that includes an overall rating of personality functioning, prototypes that describe the major personality disorder types, a system to address the traits that are associated with the prototypes, generic criteria for personality disorder, and measures of adaptive functioning [Skodol AE & Bender DS. *Am J Psychiatry* 2009].

The key adaptive capacities that are not functioning properly in individuals with personality disorders occur in the domains of the self and of interpersonal relationships. The Work Group has proposed that each of these areas might be represented by 3 subdomains. With issues that involve the self, the first is *identity integration*, which includes regulation of self-states, boundary delineation, sense of time and personal history, and self-other differentiation. The second involves the concept of *integrity of the self* —having basic esteem regulation, self-respect, agency, and realistic self-appraisal, etc. *Self directedness*, or the ability to find meaning in life and having purpose, constitutes the third subdomain. *Empathy* (the ability to accurately model another person's thoughts and emotions, identify with other people's experience, pay attention to a range of other perspectives, and understand the issues of social causality) is the first subdomain within the interpersonal area. *Intimacy*—the depth and duration of connection with others and tolerance and desire for closeness—and the *complexity and integration of representations of others* form the other 2.

The following levels of self and interpersonal functioning have been proposed, each level defined by pertinent attributes that are associated with the 5 subdomains: no impairment (ie, healthy personality functioning), and mild, moderate, serious, and severe impairment. The group is currently working on whether, how, and at what point to set a cutoff for a level of impairment in personality functioning that is consistent with a personality disorder. One of the interesting questions that the group is currently debating is whether personality disorder can be defined only in terms of pathology of the self or whether it is necessary to combine the self and the interpersonal. Determining a patient's level of self and interpersonal functioning would be the first step in assessing the presence and severity of personality psychopathology.

To more specifically characterize an individual's personality, 6 domains, representing a total of 33 personality traits on which to base prototypes, are being evaluated:

- Emotionality (eg, emotional lability, anxiousness, suspiciousness, dependency, attachment insecurity, self-harm, and pessimism)
- Introversion (eg, social withdrawal, anhedonia, reservedness, detachment, and intimacy avoidance)
- Antagonism (eg, callousness, narcissism, hostility, aggression, oppositionality, deceitfulness, manipulativeness, and conduct disorder problems)
- Disinhibition (eg, impulsivity, distractibility, reckless sensation seeking, and irresponsibility)
- Compulsivity (eg, perfectionism, indecisiveness, perseveration, rigidity, and orderliness)
- Peculiarity (eg, unusual perceptions, unusual beliefs, eccentricity, and cognitive dysregulation)

The final number of traits will likely be reduced either by elimination or combination after secondary analysis and field trials have been completed. A simple definition will