The Bipolarity Index as a Tool for Assessment and Creating Rapport: An Expert Interview With Gary Sachs, MD

Medscape Psychiatry & Mental Health. 2005; 10 (1):

Editor's Note:
How can an instrument for assessing mood disorders be useful in treatment? To find out, Elizabeth Saenger, PhD, Program Director of Medscape Psychiatry & Mental Health, interviewed Gary Sachs, MD, Director of the Bipolar Mood Program in the Clinical Psychopharmacology Unit, Director of the Harvard Bipolar Research Program, and Assistant Professor of Psychiatry at Massachusetts General Hospital in Boston, Massachusetts. Dr. Sachs is also principal investigator for the National Institute of Mental Health study on Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD).

Medscape: How do you evaluate patients for bipolar disorder?

Dr. Sachs: We certainly use the usual approach of taking a good history of the patient, but one thing that we do differently is approach the diagnostic issue not as a categorical yes-no sort of question, but more as a continuum question, so the issue becomes how much and in what ways is a patient bipolar.[1] What we do is concentrate on how the patient is now. His most extreme episode of mood elevation is our next focal point, and then we'll move systemically through family history, mental status, sexual history, childhood psychiatric illness, all the usual parts. At the end, we take all the pieces that we have and we evaluate how closely, on each of 5 dimensions, the patient resembles what might be classic for the presentation of bipolar disorder.

One of those 5 dimensions is the characteristics of the highest high period. Is this a pure euphoric mania? That might get you 20 points on that dimension. Course of illness: Are there distinct episodes with full periods of recovery in between? That might get you 20 points on the course-of-illness question. There's response to treatment, family history, and age of onset.

And with each of those dimensions, you can score 0 to 20, and that gives us a 0 to 100 score in total. That score allows us, at the end of the interview, to address the question that patients really want to know: "Do I really have this disorder?" Very few people have absolutely everything going for having bipolar disorder and very few people have nothing going for it. So we're able to give most patients a sort of quantitative sense of where they might fall between the 2 extremes.

Medscape: So that seems like it's something that's new, in a way. It's not a categorical yes or no, you're bipolar or not, but rather, "To what extent are you bipolar?"

Dr. Sachs: Yes, and we're not looking to replace the *Diagnostic and Statistical Manual* with it. What we're trying to do is answer the patient's biggest question, "How likely is it

that I have this disorder?" And it isn't that we're infallible, either; it's just that we are able to approach it more as a continuous issue, rather than as a black-and-white, yes-no.

Medscape: Do you think that would then decrease the rate of misdiagnosis, which I understand is extremely high with bipolar disorder?

Dr. Sachs: Yes, that's kind of our goal, but it's more the issue of making it clearer to the patients what the diagnosis rests on. When you come out and you give a yes-no to somebody, they don't have much confidence. When you review with them that, in fact, they have, let's say, 3 or 4 of those dimensions where they're on the money for the highest score they can have, it gives them a sense of why we have confidence in our diagnosis. Even if they don't stay with us, when they go to the next care provider, we hope they will have confidence in the diagnosis. We think a lot of patients are hurt by this constant questioning of the diagnosis. And if they don't understand what it rests on, when the next clinician evaluates them and they may take a slightly different tack, they'll go and maybe call the disorder something else, because they haven't evaluated them as systemically. And that will lead to, I think, not just misdiagnosis, but, frequently, mistreatment, and we're trying to cut down on that.

Medscape: Can you say a little more about the 5 different categories you mentioned?

Dr. Sachs: Yes. For instance, when we focus on the characteristics of the high periods, we are looking to see whether there has been even 1 clear-cut euphoric manic episode. If, when we've gone through the history, we have already found that, that's great. Yeah, that gives you great confidence, but, sometimes, the most patients have had is a mixed episode, and if it seems to have clearly met the criteria for a mixed episode, we're not quite as confident. Because when you're calling something manic because of irritability, agitation, even if there's a kind of agitated, racy quality to it, you're less confident than if you've ever found a euphoric manic episode.

Similarly, we know the classic age of onset and the peak age of onset is between 15 and 25 years. If you are here for a diagnostic assessment and there is a question of bipolarity, but your age of onset is 65 years, we're much more concerned that there might be a general medical condition causing this. We're looking for secondary causes. So what we want to do is not make the value judgments ourselves about whether this could be one thing or could be another. What we just want to do is take, if we can, a kind of rational approach to this, and that's what we get out of this so-called bipolarity index.

Medscape: Can you say a little bit more about the index?

Dr. Sachs: What we've found is that most people who have had 2 or 3 episodes of bipolar I will almost always score over 70, so scores over 70 make us pretty confident this is a bipolar I. And, obviously, if somebody is having a first episode and does not have any response to treatment, and doesn't have a course of illness, we can't have a score that's over 60. So it's not as if we're trying to establish some firm, universal set of cutoffs.

What we're trying to do is answer patients' questions about their diagnoses as honestly as we possibly can and tell them where in that gray region they are.

Of course, there's much more to assessment than finding that index, because the assessment is really only as good as the information that goes into it, so having access to actual records, having access to family members or friends, having some other corroborating source of information, is very useful. And that's not because I think patients come trying to deceive us. It's because we and most patients understand that the nature of this illness is that it distorts their perception. So assessment and treatment based on somebody's self-perception alone is no great favor.

Medscape: How does the presentation of bipolar disorder differ in children?

Dr. Sachs: That probably isn't the question to ask me, because I'm not a child psychiatrist. But, generally, you see much more dysphoria mixed in. You don't see the distinct episodes, and so there are aspects of bipolar disorder in children that are very controversial, just because they lack those classic features.

Medscape: And is it also true of adolescents, where there's more dysphoria and the episodes are less distinct?

Dr. Sachs: I think by the time you get to adolescence, it's a lot easier for you to distinguish bipolar disorder from other psychiatric problems. Adolescents are not as easy to diagnose as adults, but it is much easier to diagnose them after they are 12 years old. So prepubertal mania is the area of greatest controversy and I should leave that to child psychiatrists. But when we see 14-, 15-, 16-year-old adolescents, we usually don't have much doubt about what's going on. The adult criteria are really quite good for them.

Medscape: And how does the presentation differ in the elderly? Is there a real difference between adult and elderly adult presentation?

Dr. Sachs: What you're talking about here are 2 different issues. If you're asking how adults looks later in life if they had their first episodes between ages 15 and 30 years, what you'll see by the time they're in their 60s and 70s is that mood elevation itself is considerably less frequent than it was earlier in life and that there's much more dysphoria. And Kraepelin himself made that observation back at the end of the 19th century. So I think most people who work with geriatrics know that their bipolar patients are less and less likely to present high, though it certainly does happen.

On the other hand, if you ask, "What about new onset? Never had a mood episode before and now they're 73 years old." For men, in particular, with that presentation, you're highly likely to find some other cause. For women, you would be considerably less likely, but, still, that would be the number-one thing on my agenda to rule out, even if the episode were absolutely classic. If you see somebody with a euphoric mania at age 73 years who had never had a psychiatric history before, you should be thinking, "rule out general medical conditions."

Medscape: Have you done any research on the evaluation tool that you use to assess patients with bipolar disorder?

Dr. Sachs: Yes, back when the Mood Disorder Questionnaire was being validated, Spitzer and William's group also conducted these interviews and they sort of established that 70 is a reasonable cutoff score, given the sensitivity and specificity issues.[2]

Of course, we have data in Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD) that have yet to be analyzed only. Of course, in STEP, since we have all bipolar patients, it's not a question of what the validity is.

Medscape: Is there anything else you would like to add about your work in general with this evaluation tool?

Dr. Sachs: Yes. I think I always liked the idea that the bipolarity index is consistent with its individualizing treatment, taking people where they are. It's less important what we label them than that we identify areas of need that we can work on together. So we're less concerned about saying, "Oh, you definitely have bipolar I," than saying, "You know, you look a lot like you might have classic bipolar disorder." Yes, "Your score was 78 on this," may help people understand why we say that. But it is much more important to establish a therapeutic relationship and make sure that we approach treatment in much the same way. So we do not tell people that they have to accept our recommendations for the rest of their life. This is, I think, a kind of practice that can be demoralizing to patients and lead to lower levels of what we refer to as concordance in the treatment, the degree of agreement between patient and care provider about what the appropriate treatment is. So if I ask somebody to accept lifelong treatment with what I recommend when I first meet them, that's like asking somebody on their first date to get married and have a family. It's both unnecessary and unproductive, in my opinion.

So what we'd like to do is -- analogous to getting to a second date if things are comfortable for patients -- establish their individual responses to treatment. We'll begin with the evidence-based recommendations. We'll teach the patients what the profiles of those treatments are like and give them some choice. And then what we do is integrate measurement into the management so that we're not betting that, "Oh, this is definitely going to work." All we're really doing is starting out on a kind of journey with them and having these measurements in which they participate. -- They have a hand in the assessment process as well as in the decision-making about treatment process.

If we work together and we really are tracking response, we will get to the right treatment for a patient a lot sooner, and their reluctance to try something that might be beneficial, I think, can be greatly reduced by having a good working relationship with a doctor who's not afraid to try things that the patient would like to try. As long we measure the results, we can have those trials go forward and we can decide this either worked or it didn't, rather than just endlessly pile on treatments.

Medscape: How does your term "concordance" for a "good therapeutic alliance" differ from, let's say, "motivational interviewing," or "adherence," or other terms that have been proposed?

Dr. Sachs: Well, part of it really does use the pieces from motivational interviewing to perhaps get there, and we really try to be good negotiators, not in the sense of getting people to adopt our positions, but to work to establish external criteria to judge these measurements, so we can have an iterative approach to treatment.

So we're okay with the idea that concordance is a dynamic process over time and that by working with patients, maybe with motivational interviewing, maybe just with good common sense, we can establish what worked for them and what didn't. And, over time, I'm willing to adopt the patient's position. If they tell me that they want to try salad dressing and it works, I don't mind that, as long as we've tried it, we've measured it, it seems to be working, I can go with that. But if it's not working, I'm going to ask them to do one of the evidence-based treatments.

And I think the willingness to work along with patients in that way brings almost all of them to a position of being concordant. And it's not just about their meds, but about whether they're going to get treatment for substance abuse. Are they going to deal with lifestyle issues? Work on their weight? Try other potential occupational strategies to lessen the stress in their life? There are many, many things for us to establish agreement about. And the proof is in the pudding. We try them out, we see the results, and we go with 'em.

Medscape: Do you also recommend psychotherapy as an adjunct to treatment?

Dr. Sachs: We really do. We've had very good luck with several forms of psychosocial interventions, and we start off with what we call a collaborative care module. Collaborative care is meant to be, initially, no more than introducing the patient, through a workbook and a videotape, to very basic information about their illness, the available treatments, and encouraging their family, also, to watch that video. This gets everybody on the same page. The ultimate goal is to have them have a written treatment plan.

In the process of doing that, we will come to know the patient, and perhaps that's when a recommendation for a formal course of cognitive-behavioral therapy, interpersonal social living therapy, or family-focused therapy may come into it. Those are the treatments that are in STEP and ones that we've come to value.

Medscape: Who writes the treatment plan?

Dr. Sachs: Well, the patients initially are given a shot at doing it themselves. And the truth is a fair number of them, probably between 30% and 40%, can just take that and run with it. But when they've not done it or they've not done well, then we will give them 3 sessions with one of our trained psychologists to help them work up that plan. So, with assistance, everybody can do it, but it is meant to start out largely as a self-directed

process. So they get a chance to do it, then they get a chance to do it with assistance, and then they may or may not go on to have formal therapy.

Medscape: Thank you very much for sharing your thoughts with Medscape.

Supported by an independent educational grant from GlaxoSmithKline.

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2. Hirschfeld RM, Williams JB, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. Am J Psychiatry. 2001;158:1743-1744.

Disclosure: Elizabeth Saenger, PhD, has disclosed no relevant financial relationships.

Disclosure: Gary Sachs, MD, has disclosed that he owns stock, stock options, or bonds in Concordant Rater Systems, LLC, and has received grants for educational activities from GlaxoSmithKline, AstraZeneca, Wyeth, Eli Lilly, Sanofi, and Abbott Laboratories. Dr. Sachs has also disclosed the he served as advisor or consultant for GlaxoSmithKline, Pfizer, AstraZeneca, Wyeth, Eli Lilly, Sanofi, and Abbott Laboratories.