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Review Article

Current challenges and Indian perspectives in the diagnosis and management of bipolar disorders

G. Prasad Rao[1]*, Amrit Pattojoshi[2]

[1]Asha Hospital, Hyderabad, Telangana, India
[2]Hi-Tech Medical College, Bhubaneswar, Odisha, India

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***Correspondence:**
Dr. G. Prasad Rao,
E-mail: prasad40@gmail.com

ABSTRACT

Bipolar disorders (BDs) are episodic illnesses characterised by alternating episodes of mania or hypomania and depression, or mixtures of manic and depressive features. BDs present many diagnostic and therapeutic challenges because of their varying clinical course, symptoms, severity and the presence of comorbidities. They severely burden healthcare systems, particularly in low-income and middle-income countries. In India, managing bipolar disorder is challenging, due to inadequate resources, poor knowledge about the disorder or its treatment, and limited access to healthcare facilities. These disorders impact a large portion of the Indian population, thus highlighting an urgent need to effectively facilitate better diagnosis and management of mental disorders across the country. A careful assessment of previous manic or hypomanic episodes and early identification of comorbidities helps predict disease course and treatment options. Treatment of BDs usually combines medications and psychotherapy. In Indian clinical settings, the first-line treatment for BDs includes pharmacotherapy with mood stabilisers, such as divalproex, lithium, anticonvulsants, and antipsychotics. Psychotherapy, along with lifestyle approaches are useful adjuncts. To reinforce the overall management of BDs, focused group discussions were conducted among 87 psychiatrists across nine cities in India, to gather insights about the burden, diagnostic challenges, and treatment approaches. This review discusses expert insights on optimal diagnostic and treatment approaches for BDs, focusing on psychiatric and non-psychiatric comorbidities, prevalent among Indian patients with type I and II bipolar disorders. It also covers lithium adverse effects, divalproex-place in therapy, and the use of anti-depressant a risk factor for rapid cycling.

Keywords: Bipolar disorder, Mood stabilisers, Non-psychiatric, Psychiatric, Psychotherapy

INTRODUCTION

Bipolar disorders (BDs) are mental disorders and are among the leading causes of disability worldwide.[1] Individuals affected by BDs have higher rates of other mental health disorders, including anxiety and comorbid illnesses.[2] Patients with BDs are often initially diagnosed with unipolar depression, schizophrenia or substance-induced psychotic disorder.[1] Due to varying symptoms and severity, BDs represent a major clinical challenge for timely diagnosis and treatment. However, adequate understanding, timely diagnosis, and appropriate use of medications for effective management are critically important in patients with BDs, yet insufficiently determined.[3] According to the findings of the India state-level disease burden initiative as part of the global burden of diseases, injuries, and risk factors study, the prevalence of BD among the Indian population is 7.6 million.[4] There has been extensive research on BDs worldwide. However, not many articles have reported on the challenges associated with the diagnosis and management of BDs in India. Hence, the present article is intended to provide insights into significant aspects of BDs to optimise the

appropriate diagnosis and management of BDs in the Indian population.

To understand the diagnostic challenges and management of BDs in current clinical practice, focused group discussions were conducted with 87 psychiatrists across nine cities in India. A comprehensive literature search was carried out using PubMed with Boolean operators and the search terms 'BD', 'mental disorder', 'manic-depressive disorder' and 'substance use disorder'. Data were accessed from six meta-analyses and 41 published research articles and systematic reviews. The current consensus summarises expert insights, recommendations and supporting evidence on optimising diagnostic challenges and treatment strategies for BD.

BURDEN AND CAUSES OF BD

BDs a chronic and complex mood disorder, is characterised by a combination of manic, hypomanic, and depressive episodes, with subsyndromal symptoms enduring between mood episodes.[5] Globally, mental disorders affect a large proportion of the population and impose a serious challenge to healthcare, especially in low-income and middle-income countries.[6]

In India, one in seven individuals is affected by mental disorders, and the proportional contribution to the total disease burden has almost doubled since 1990.[4] BDs manifest predominantly during adulthood.[7] In India, the prevalence of BDs is 0.6% irrespective of gender, with disability-adjusted life-years (DALYs) ranging up to 6.9%.[4] BDs usually manifest in the early twenties but can vary.[8] The prevalence of BD increases during adolescence and reaches a plateau during most of adulthood, with a slight decline in older age groups.[4] Trigger factors include genetic predisposition and environmental and psychological factors.[8]

Substance use disorders (SUDs), impose a significant adverse impact and are attributable to the use of one or more substances that cause distress. In India, the use of various non-medical psychoactive substances is increasingly leading to major public health hazards.

The drugs that lead to abuse, include cannabis, stimulants, tobacco, alcohol, opioids, sedative-hypnotics, hallucinogens, anxiolytic agents, inhalants and the others.[8,9]

DIAGNOSIS OF BD

Definition

In 1957, Leonhard first used the term 'bipolar' for disorders comprising both manic and depressive symptoms. Later, in 1980, the diagnostic and statistical manual of mental disorders (DSM) used the term BD to replace 'manic depression.'[10]

Classification

BDs are categorised as BD I, BD II or cyclothymic disorder.[11] BD I is a manic-depressive disorder that can occur both with and without psychotic episodes, whereas in BD II, depressive and manic episodes alternate, are typically less severe, and do not inhibit function. Cyclothymic disorder is a cyclic disorder that causes brief episodes of hypomania and depression.[11]

Diagnostic challenges

Approximately 70% of patients are initially misdiagnosed, and more than one-third remain misdiagnosed for 10 years or more. A crucial diagnostic challenge remains the difficulty of distinguishing BD from unipolar major depressive disorder (MDD).[12,13] A comparison of bipolar and unipolar depression features is described in Table 1.[13] Bipolar I and II disorders are difficult to diagnose accurately in clinical practice, predominantly in their early stages. In patients with BD experiencing depressive episodes, the mean delay between illness onset and diagnosis is 5-10 years. A primary reason is the challenge of differentiating BD from unipolar depression in patients with a depressive episode and patients with no clear history of mania or hypomania.[10]

Misdiagnosis of BD has many potentially deleterious consequences, such as the prescription of inappropriate drugs, poor clinical outcomes and high healthcare costs. Furthermore, two-thirds of patients with unipolar depression experience non-responsiveness to first-line antidepressants, while one-third do not attain full remission from symptoms after four treatments.[10] Diagnosing BD in children is even more challenging, as their presentation may differ.[14] Failure to diagnose BDs imposes serious consequences, including high morbidity and mortality in patients with BDs compared to those with MDD.[15] Confounding comorbidities associated with BDs also contribute to diagnostic challenges.[16]

Comorbidities associated with BD

SUDs are highly prevalent in patients with bipolar I and II disorders. Men have higher rates of SUDs compared to women.[17] SUDs worsen outcomes in patients with BDs and affect the overall course of the condition due to early onset, frequent and mixed episodes, and slow symptom remission.[18] Anxiety disorders include panic disorder, agoraphobia, social phobia, simple phobia, obsessive-compulsive disorder, post-traumatic stress disorder and generalised anxiety disorder.[19] Cluster B personality disorders include antisocial personality disorder, borderline personality disorder, histrionic personality disorder and narcissistic personality disorder.[20] Other medical conditions, such as asthma, hyperlipidaemia, type 2 diabetes, epilepsy, kidney disease, gastric ulcers, hypertension, osteoarthritis, multiple sclerosis, and thyroid disease can cause mania, hypomania or depression episodes.[19] Early identification of comorbidities can help

treating and predicting disease course. Assessment of genetic predisposition, suicidal tendencies, childhood stress, and poor response to antidepressants can facilitate early diagnosis.[21]

Table 1: Comparison of bipolar and unipolar depression features.[13]

Parameters	Bipolar depression	Unipolar depression
Mania episodes	Present	Absent
Common complaints	Retarded/withdrawn with hypersomnia tendency	Anxiety and anger common with somatic complaints
Weight loss and agitation	Not common	Common
Age of onset	Relatively young age	Relatively old age
Atypical depression symptoms	More common	Less common
Family history of BD	More common	Relatively less common
Pattern of illness	Recurrent with relatively brief episodes	Longer episodes with lesser recurrence
Antidepressant therapy	Less response	More responsive
Postpartum onset and premenstrual syndrome	More common	Less common
Psychotic features	More common	Less common
Mood lability and seasonal pattern	More common	Less common
Substance use and suicide attempt	More common	Relatively less common

Current diagnostic criteria

A high index of suspicion must be maintained for the diagnosis of BD. The first step is the identification of the current or past manic, hypomanic, and depressive episodes, followed by definitive history taking, work-up and diagnosis.[22] A mood episode may consist of a combination of manic or depressive symptoms or a combination defined in the DSM-5.[23]

According to the eleventh version of the international classification of diseases (ICD-11), BDs are subdivided into bipolar I and bipolar II disorder, with analogous diagnostic criteria to those mentioned in DSM-5. However, to diagnose bipolar I disorder, the existence of at least one past or present manic or mixed episode is mandatory. Depressive episodes may occur or may not, but are not obligatory. In contrast, to diagnose bipolar II disorder, the incidence of at least one hypomanic and one depressive episode during the course of the illness is required. Moreover, a hypomanic or a mixed episode no longer qualifies for an independent diagnosis. The same is true for recurrent hypomanic episodes in the absence of depressive episodes.[24] The ICD-11 guidelines are currently out for consultation and comment, and it is expected that the ICD-11 will be in worldwide use from 2022.[25] The Canadian network for mood and anxiety treatments (CANMAT) and international society for BDs (ISBD) 2018 guidelines also provide comprehensive principles related to the diagnosis and management of BDs.[26]

Clinicians must strictly adhere to diagnostic criteria to improve the accuracy of diagnosis. It is crucial to complete a careful psychiatric history, including information about first-degree relatives, and consider any suspected periods of increased activity, irritability or other behavioural changes. Collateral information from friends and family members should be incorporated wherever possible. Continuous symptom monitoring, such as mood charting, can also help to detect bipolarity that may only become apparent over time. Diagnosis can be confirmed more confidently when episodes are observed prospectively.[26] It should be emphasised that bipolar II disorder is not a milder form of bipolar I disorder, but separate diagnosis.[27]

Aids to diagnose the basic subtypes of bipolar mood episodes

DSM-5 criteria have been prescribed for diagnosing major depressive or manic/hypomanic episodes.[22] For major depressive episodes, essential diagnostic criteria include the assessment of a consistently depressed mood and persistent anhedonia. Symptom assessment includes evaluating changes in appetite or body weight, sleep pattern changes or insomnia, persistent fatigue, agitation, feeling of worthlessness or excessive guilt, problems with concentration or decision-making, and/or suicidal thoughts. For manic or hypomanic episodes, essential criteria are consistently elevated, expansive or irritable mood. For symptom assessment, abnormal self-esteem, reduced sleep needs, increased talkativeness, racing thoughts or ideas, abnormal distractibility, increased energy or goal-directed activity, or abnormally risky behaviours should be evaluated.[22]

In Indian settings, the diagnosis of BD should be based on current diagnostic criteria. This enables communication among various clinicians and optimises management based on evidence-based recommendations. During the initial phase of the disorder, symptoms can be confusing, it can occasionally be difficult to differentiate manic symptoms from other psychiatric syndromes such as schizophrenia, acute and transient psychosis, and other psychiatric disorders. The possibility of SUD or disorders secondary to organic causes should be considered when

the symptoms are atypical or when there is evidence of substance use or underlying organic causes. Seldom, establishing a definite diagnosis of BD may require time.[28]

Expert opinion: Indian perspective

Early diagnosis is a major challenge in Indian settings. One must look beyond symptoms to factors such as the age of onset, long-term longitudinal family history, age, and non-response to antidepressants. In the course of phases like hypomania and mania, substance abuse leads to a missed diagnosis. In the depressive phase of the first episode, factors such as a family history of suicide, hyperthymic personality or substance abuse in the family are important clues for identifying BD. For patients with borderline personality disorder, symptoms such as anxiety, irritability and first depressive episode and substance abuse, are important parameters for diagnosis.

Management of BDs

Treatment of BD usually combines the use of medications and various forms of psychotherapy.[27] Patients are usually managed in the outpatient setting; however, some serious cases may require inpatient management.[28]

Available treatment options for the management of BD

The available treatment options for BD include mood stabilisers, antidepressants, antipsychotic medications, electroconvulsive therapy (ECT), adjunctive medications and psychosocial interventions (Figure 1).[28]

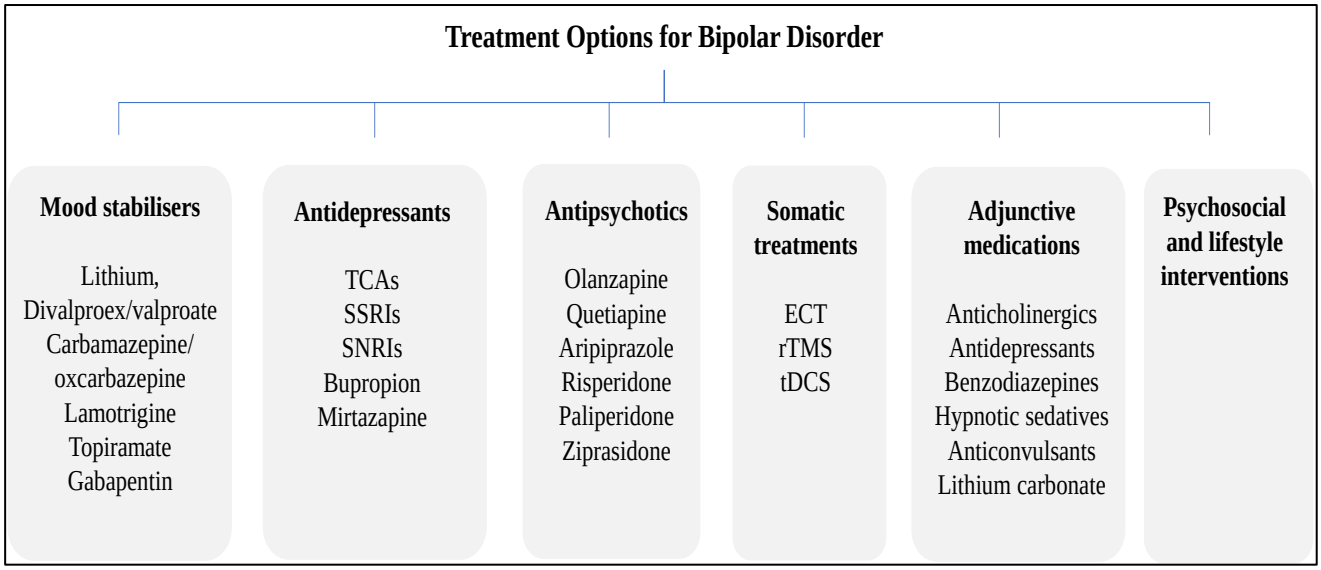

Figure 1: Treatment strategies for the management of BD according to the experts.

ECT, electroconvulsive therapy; rTMS, repetitive transcranial magnetic stimulation; SNRIs, serotonin and norepinephrine reuptake inhibitors; SSRIs, selective serotonin reuptake inhibitors; tDCS, transcranial direct current stimulation; TCAs, tricyclic antidepressants.

MANAGEMENT OF BD I

The treatment of bipolar I disorder can be divided into three stages: acute treatment of manic or depressive episodes, improvement phase and maintenance phase.[29]

Acute treatment of manic episodes

Mood stabilisers are mainstay of pharmacological treatment for manic episodes, with atypical antipsychotics or benzodiazepines used as needed for agitation. First-line mood stabilisers are lithium and divalproex. Onset of action of lithium is slower than that of antipsychotic drugs.[22,29] Lithium is effective in managing classic manic episodes, while divalproex may be more effective for mixed episodes/rapid cycling. When lithium is combined with commonly used medications such as nonsteroidal anti-inflammatory drugs and the anti-hypertensive medications, its levels can increase, thereby raising the risk of toxicity.[22]

Moreover, long-term use of lithium has been associated with adverse effects on thyroid, renal and parathyroid functioning.[22] Divalproex is effective in managing BD with a good response in acute mania and mixed episodes. Divalproex shows better antimanic effects when the dose is increased within its therapeutic range. An oral loading dose of 20-30 mg/kg per day may result in a more rapid antimanic response than conventional dosing.[22,28] Other options for mood stabilisers include carbamazepine, oxcarbazepine, and atypical antipsychotics such as aripiprazole, olanzapine or risperidone. Careful monitoring of mood symptoms and blood levels is essential. If monotherapy is not sufficient, a second mood stabiliser and/or atypical antipsychotic can be added.[29] Figure 2 outlines the flowchart for the management of hypomania/ mania/mixed episodes.[28]

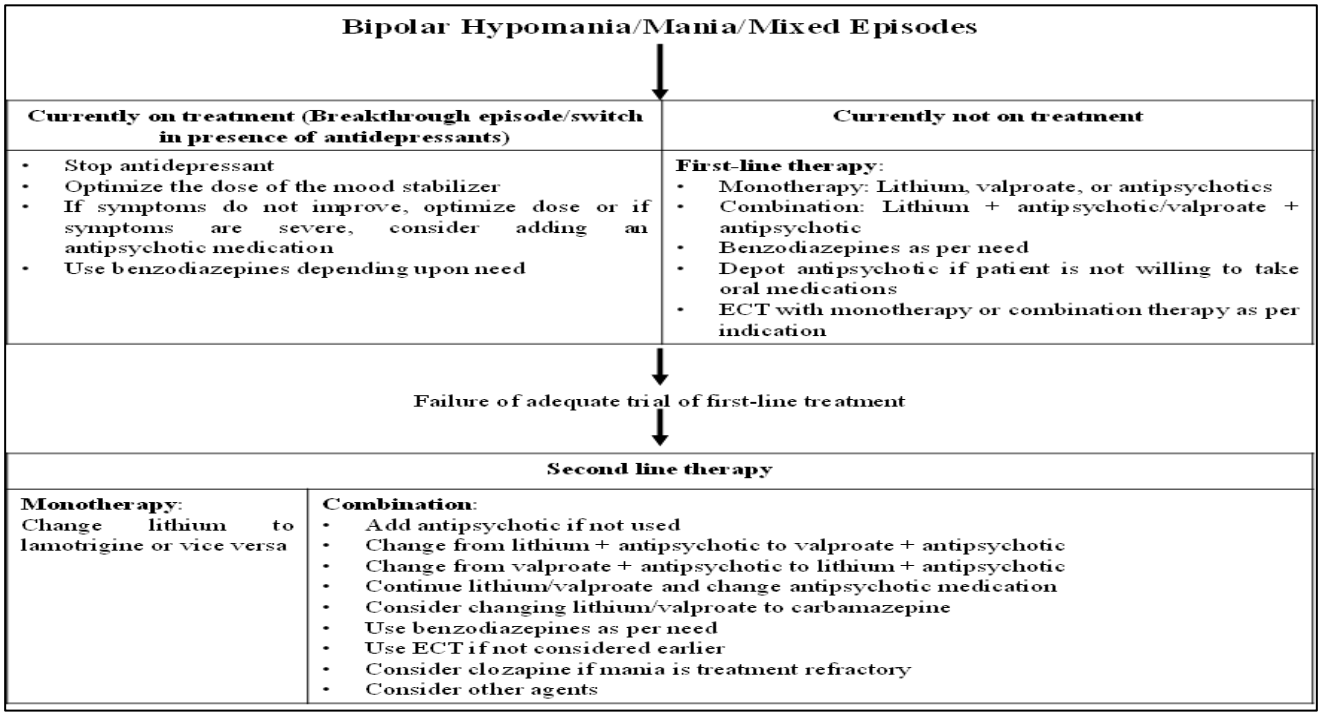

Figure 2: Management of hypomanic, manic or mixed episodes.[28]

Acute treatment of depressive episodes

The first-line treatments for bipolar depressive episodes include lithium or lamotrigine monotherapy. In severe cases, a second mood stabiliser such as divalproex or lithium can be added. For patients with psychotic features, atypical antipsychotics can be included. Use of antidepressant monotherapy is not indicated in BD cases, as it can cause rapid cycling/ switches into mania/ hypomania.[29]

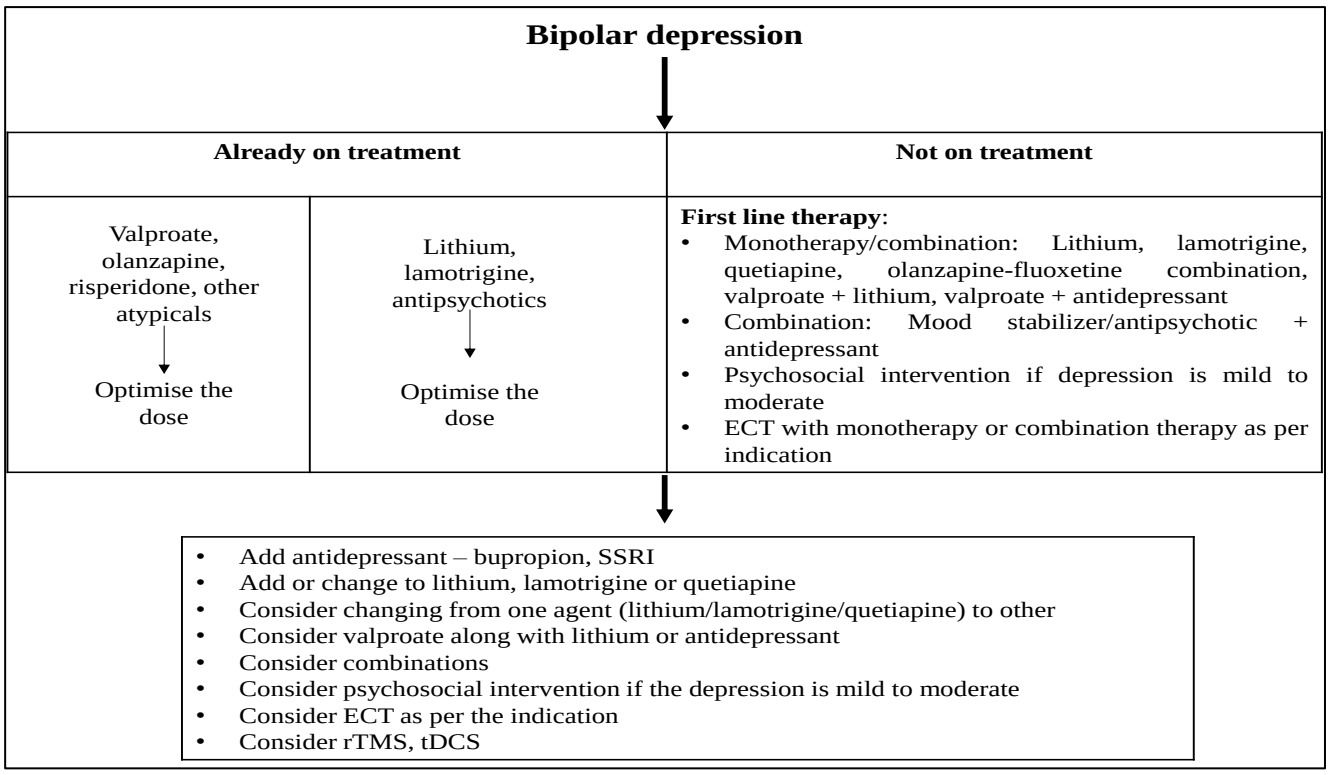

Figure 3: Management of bipolar depressive episodes.[28]

ECT, electroconvulsive therapy; rTMS, repetitive transcranial magnetic stimulation; SSRIs, selective serotonin reuptake inhibitor

Improvement phase of treatment

During an average of six months in this phase, patients show symptom improvement but remain vulnerable to mood instability. Frequent assessment of symptoms and adjustment of medications based on response is required during this phase. Psychotherapy should focus on identifying and addressing trigger factors for mood changes and managing relationships, work or finances. If there is no relapse, patients are considered to have recovered and have entered the maintenance phase of treatment.[29] In the improvement phase, medications should be continued from the acute phase, with frequent assessment of dosage and side-effects monitoring.[29]

Maintenance phase of treatment

Goal of maintenance phase is relapse prevention. Mood stabilisers remain mainstay for continued treatment.[29] Comorbid conditions such as SUDs, anxiety, medical illness and medication side effects should be managed appropriately. The use of cannabis may worsen manic episodes and overall patient outcomes in BD.[30] lithium and divalproex have shown good responses in many patients when used as monotherapy for maintenance treatment with tapering off of adjunctive medicines. First-line options are lithium, divalproex and lamotrigine; carbamazepine and atypical antipsychotics are additional options. Lithium or lamotrigine is used for the prevention of depressive episodes, while divalproex and carbamazepine are used for rapid cycling. Antidepressants should usually be discontinued or tapered off, except in cases of relapses.[31,32]

MANAGEMENT OF BIPOLAR II DISORDER

Treatment options for bipolar II disorder are closely aligned with those for bipolar I disorders.[22] Characterised by hypomanic episodes alternating with major depressive episodes without mania or psychosis, bipolar II disorders are less debilitating than bipolar I disorders; yet, it imposes significant morbidity and mortality if left untreated. Coexisting psychiatric conditions like schizophrenia, schizoaffective disorder, posttraumatic stress disorder, substance abuse and personality disorders complicate the management of bipolar II disorders.[33,34]

Hypomania treatment

Treatment options for hypomania are similar to those for mania. For the initial treatment of hypomanic episodes, mood stabilisers can be used as monotherapy with or without adjunctive benzodiazepines. Antipsychotics are also used. Combination therapy with two mood stabilisers or mood stabilisers and antipsychotics can be used in patients with poor response to monotherapy.[22]

Antipsychotics

Some first- and second-generation antipsychotics, such olanzapine, quetiapine, risperidone, ziprasidone and aripiprazole, used either as monotherapy or combination with divalproex, lithium, and carbamazepine, have found to be efficacious in treating acute mania, moderate-to-severe hypomania, and mixed states. Patients should be monitored for weight, waist circumference, blood pressure, and serum glucose and lipid levels. Extrapyramidal side effects are lesser with olanzapine or quetiapine compared to first-generation antipsychotics such as aripiprazole, ziprasidone and risperidone.[26,35-37]

Antidepressants

Monotherapy with antidepressants should be avoided in bipolar I or II disorders due to the increased frequency of mood cycles and the development of rapid cycling. Antidepressants can be safely used in combination with divalproex and Lithium, which may reduce the risk of switching into manic and hypomanic episodes. A few studies have shown the benefits of fluoxetine in the relapse prevention of bipolar II depressive episodes.[22,38]

Maintenance treatment

Acute-phase treatments that are effective should be continued to prevent early relapses.[22]

Management of rapid cycling

In patients with rapid cycling and active psychosis, antipsychotic drugs such as quetiapine, aripiprazole, olanzapine, lithium, carbamazepine, lamotrigine, and valproate either alone or in combination with a mood stabilizer like divalproex or lithium can be recommended.[39] Combination therapy, often involving antipsychotic drugs and mood stabilisers or the use of two mood stabilisers, has shown benefits in rapid cycling for relapse prevention.[39]

Antidepressant use, SUDs, and thyroid disease are risk factors for rapid cycling; hence, appropriate screening for substance abuse, thyroid management, and avoidance of antidepressant drugs are recommended in the management of rapid cycling in patients with bipolar I and II disorders.[40]

MANAGEMENT OF BD WITH COMORBIDITIES AND SUBSTANCE ABUSE

BD has the highest rates of comorbid SUDs among DSM axis I diagnoses. A lifetime SUD diagnosis is made in about 60% of patients with BD I. The most commonly abused substance by BD patients is alcohol followed by cannabis, amphetamines, and cocaine excluding tobacco.[41-43]

A multifaceted approach with pharmacotherapy and psychosocial interventions is recommended for the management of BD with SUDs due to the risk of severe aggressive behaviour or suicide. Effective agents for the management of BD with alcoholism are valproate and quetiapine.[17,44]

DIVALPROEX: PLACE IN THERAPY

Divalproex is useful in the management of BD and is effective against acute mania and mixed episodes. It also efficacious in the prevention of mania and depression.[10] A study by Davis et al demonstrated greater improvement in symptoms of depression and anxiety with divalproex versus placebo in 25 patients with bipolar I depression. A two-fold higher improvement in depression symptoms and a three-fold improvement in anxiety symptoms were reported for divalproex over placebo. Divalproex was well-tolerated and could probably be safely used without worsening depressive symptoms.[45]

In a six-week study by Muzina et al the efficacy of divalproex was compared to placebo in mood stabiliser-naive patients with bipolar I or II depression. Among 54 patients with BD type I or II, divalproex enabled statistically significant improvement in depression rating scale scores compared with placebo from week 3 onwards. Divalproex had a more than three-fold higher response rate and more than two-fold greater remission rate compared with placebo. Therefore, divalproex is efficacious and reasonably well tolerated in the acute treatment of mood stabiliser-naive patients with bipolar depression.[46]

Gyulai et al analysed the effect of divalproex on multiple dimensions of depressive morbidity in BD. Bipolar I patients were randomised to maintenance treatment with divalproex, lithium, or placebo in a 2:1:1 ratio over 52 weeks. Divalproex-treated patients experienced less worsening of depressive symptoms than Lithium-treated patients during maintenance. Divalproex improved several dimensions of depressive morbidity and reduced the probability of depressive relapse in BD patients with a more severe course of illness. A post hoc analysis evaluated the subgroup of patients who received a selective serotonin reuptake inhibitor (SSRI). Divalproex-treated patients remained in the study significantly longer than those treated with placebo or SSRI. An SSRI without divalproex was not very effective.[47] Scanty evidence supports the use of lithium for anti-alcohol or anti-drug medication in treating BD-SUD patients. Lithium shows little efficacy in reducing cocaine use in cocaine-dependent patients with BD. BD-SUD patients are more likely to comply with sodium valproate than with Lithium.[48]

Salloum et al. enrolled 59 alcohol-dependent bipolar I disorder patients in a study and found that divalproex combined with lithium was more effective in reducing the number of drinking days and drinks per day, and increased time of abstinence compared to lithium plus placebo. Divalproex was safe and well tolerated, and liver function improved with its use.[49] Divalproex has also been used to treat BD comorbid with cocaine dependence. In another small open-label study conducted by Salloum et al., 15 patients receiving divalproex plus counselling for mood and SUDs were followed for six weeks. The study reported increased cocaine-abstinence days and decreased money spent on cocaine and on the cocaine use severity index.[50]

EXPERT OPINION: INDIAN PERSPECTIVE

Concerning acute mania, first-line mood stabilisers such as divalproex (1 g), Lithium, and atypical antipsychotics are preferred, while benzodiazepines are recommended in acute cases. Lithium can be used as a mood stabiliser for bipolar depression, particularly in suicidal cases and mild cases, but it is associated with side effects. Continuous monitoring is necessary for patients on lithium, which is why experts often prefer divalproex. In cases of acute mixed BD, the preferred treatment is a combination of a mood stabiliser and an atypical antipsychotic. Divalproex combined with risperidone, aripiprazole or olanzapine is considered the best combination. For maintenance therapy, an antidepressant is required as the first choice, especially in women. Olanzapine, fluoxetine and lamotrigine are commonly used in combination. Ketamine can be beneficial in certain patients when used alongside olanzapine and fluoxetine. In cases of severe depression, lithium with lamotrigine or lurasidone may be added to the maintenance dose. For very depressed patients, bupropion can be added. For bipolar II disorders, the combination of fluoxetine and olanzapine is the first treatment choice. Quetiapine is the second treatment choice, while lamotrigine is the third. In schizophrenia, atypical antipsychotics such as olanzapine, lurasidone or aripiprazole are preferred. The combination of divalproex with atypical antipsychotics is considered the first choice of treatment.

KEY RECOMMENDATIONS FOR PRACTICE

Adequate screening should be implemented to support accurate diagnosis, psychotherapy, and follow-up. Effective single agents for acute mania include valproate, lithium and some antipsychotics. Effective combination therapies for acute mania include valproate or lithium with quetiapine or risperidone. Quetiapine and cariprazine may be effective as monotherapies for acute bipolar depression. Lurasidone combined with lithium or valproate may be an effective treatment strategy for acute bipolar depression. Lithium, quetiapine or a combination of quetiapine and lithium or divalproex may be effective for the maintenance of BD.

CONCLUSION

BDs are prevalent and recurrent mental health conditions that significantly impact individuals and their family members. The variability in severity and recurrence makes BD challenging to diagnose and manage effectively. Comorbidities, such as SUDs, anxiety and chronic medical conditions, are commonly associated with BD and complicate treatment. In the current Indian context, optimising diagnosis and treatment remain a challenge. Updated diagnostic criteria and specifiers assist physicians in recognising episode severity and prognosis, particularly

with regard to mixed features and anxious distress. Pharmacotherapy with mood stabilisers, including divalproex, lithium, anticonvulsants and antipsychotics, represents the first-line treatment and should be maintained to prevent relapse risk. Complementary psychotherapy and lifestyle modifications are valuable adjuncts to pharmacotherapy.

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REFERENCES

1. Lublóy Á, Keresztúri JL, Németh A, Mihalicza P. Exploring factors of diagnostic delay for patients with bipolar disorder: a population-based cohort study. BMC Psychiatry. 2020;20(1):75
2. Marzani G, Price Neff A. Bipolar disorders: evaluation and treatment. Am Fam Physician. 2021;103(4):227-39.
3. Baldessarini RJ, Vázquez GH, Tondo L. Bipolar depression: a major unsolved challenge. Int J Bipolar Disord. 2020;8(1):1.
4. India State-Level Disease Burden Initiative Mental Disorders Collaborators. The burden of mental disorders across the states of India: the Global Burden of Disease Study 1990-2017. Lancet Psychiatry. 2020;7(2):148-61.
5. Jain A, Mitra P. Bipolar affective disorder. [Updated 2023 Feb 20]. In: StatPearls. Treasure Island (FL): StatPearls Publishing; 2024.
6. Institute of Health Metrics and Evaluation. GBD compare data visualisation. Available at: https://vizhub.healthdata.org/gbd-compare/. Accessed on 27 July 2024.
7. Indian Council of Medical Research. Release of GBD India Mental Disorders Paper, 2019. Available at: https://main.icmr.nic.in/sites/default/files/press_release_files/PR_GBD_India_Mental_Disorders_Paper_0.pdf. Accessed on 10 August 2024.
8. Rowland TA, Marwaha S. Epidemiology and risk factors for BD. Ther Adv Psychopharmacol. 2018;8(9):251-69.
9. Datta D, Pandey SK, Datta S, Verma Y. Comorbid physical and mental health illness of prescription opioid abusers attending de-addiction centers of Sikkim: A Northeastern State of India. J Pharmacol Pharmacother. 2018;9(3):160-4.
10. Phillips ML, Kupfer DJ. Bipolar disorder diagnosis: challenges and future directions. Lancet. 2013;381(9878):1663-71.
11. Bipolar Definition and DSM-5 Diagnostic Criteria. Available at: https://www.psycom.net/bipolar-definition-dsm-5/. Accessed on 14 December 2024.
12. Practice guideline for the treatment of patients with bipolar disorder. Second Edition. 2002. Available at: https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/bipolar.pdf. Accessed on 15 August 2024.
13. Singh T, Rajput M. Misdiagnosis of bipolar disorder. Psychiatry (Edgmont). 2006;3(10):57-63.
14. Aguirre L. Navigating the diagnostic challenges of bipolar disorder in youth. JAAPA. 2021;34(8):21-7.
15. Beyer JL, Ketter TA, McIntyre RS, Suppes T. Managing bipolar depression: an evidence-based approach. Current Psychiatry 2013;12(10):S1-8.
16. Salloum IM, Brown ES. Management of comorbid BD and substance use disorders. Am J Drug Alcohol Abuse. 2017;43(4):366-76.
17. Hunt GE, Malhi GS, Cleary M, Lai HMX, Sitharthan T. Prevalence of comorbid bipolar and substance use disorders in clinical settings, 1990-2015: systematic review and meta-analysis. J Affect Disord. 2016;206:331-49.
18. Practice guideline for the treatment of patients with substance use disorders. Second Edition. 2006. Available at: https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse.pdf. Accessed on 11 May 2024.
19. Nakagawa A, Grunebaum MF, Sullivan GM, Currier D, Ellis SP, Burke AK, et al. Comorbid anxiety in bipolar disorder: does it have an independent effect on suicidality? Bipolar Disord. 2008;10(4):530-8.
20. Forty L, Ulanova A, Jones L, Jones I, Gordon-Smith K, Fraser C, et al. Comorbid medical illness in bipolar disorder. Br J Psychiatry. 2014;205(6):465-72.
21. Alda M, Manchia M. Personalized management of bipolar disorder. Neurosci Lett. 2018;669:3-9.
22. Bobo WB. The diagnosis and management of bipolar I and II disorders: clinical practice update. Mayo Clin Proc. 2017;92(10):1532-51.
23. McCormick U, Murray B, McNew B. Diagnosis and treatment of patients with bipolar disorder: A review for advanced practice nurses. J Am Assoc Nurse Pract. 2015;27(9):530-42.
24. Severus E, Bauer M. Diagnosing bipolar disorders: ICD-11 and beyond. Int J Bipolar Disord. 2020;8(1):4.
25. Angst J, Ajdacic-Gross V, Rössler W. BDs in ICD-11: current status and strengths. Int J Bipolar Disord. 2020;8(1):3.
26. Yatham LN, Kennedy SH, Schaffer A, Parikh SV, Beaulieu S, O'Donovan C, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) and International Society for BDs (ISBD) collaborative update of CANMAT guidelines for the management of patients with BD: update 2009. Bipolar Disord. 2009;11(3):225-55.
27. Bipolar treatment: Are bipolar I and bipolar II treated differently? 2018 Available at: https://www.mayoclinic.org/diseases-conditions/bipolar-disorder/expert-answers/bipolar-treatment/faq-20058042. Accessed on 11 May 2023.

28. Shah N, Grover S, Rao GP. Clinical practice guidelines for the management of BD. Indian J Psychiatry. 2017;59(1):S51-66.
29. Bipolar I Disorder. Johns Hopkins Psychiatry Guide, 2017. Available at: https://www.hopkinsguides.com/hopkins/view/Johns_Hopkins_Psychiatry_Guide/787045/all/Bipolar_I_Disorder. Accessed on 16 August 2021.
30. Gibbs M, Winsper C, Marwaha S, Gilbert E, Broome M, Singh SP. Cannabis use and mania symptoms: a systematic review and meta-analysis. J Affect Disord. 2015;171:39-47.
31. Oedegaard KJ, Alda M, Anand A, Andreassen OA, Balaraman Y, Berrettini WH, et al. The Pharmacogenomics of BD study (PGBD): identification of genes for Lithium response in a prospective sample. BMC Psychiatry. 2016;16:129.
32. Hou L, Heilbronner U, Degenhardt F, Adli M, Akiyama K, Akula N, et al. Genetic variants associated with response to Lithium treatment in bipolar disorder: a genome-wide association study. Lancet. 2016;387(10023):1085-93.
33. Stovall J, Keck P, Solomon D. Bipolar disorder in adults: epidemiology and diagnosis. UpToDate. https://medilib.ir/uptodate/show/678. Accessed on 16 August 2024.
34. Herb K, Stuart A. Kirk. Diagnostic and Statistical Manual of Mental Disorders. In: Social Work. 4th ed. Washington, DC: American Psychiatric Association. 1995;286-7.
35. Smith LA, Cornelius V, Warnock A, Tacchi MJ, Taylor D. Pharmacological interventions for acute bipolar mania: a systematic review of randomized placebo-controlled trials. Bipolar Disord. 2007;9(60):551-60.
36. Scherk H, Pajonk FG, Leucht S. Second-generation antipsychotic agents in the treatment of acute mania: a systematic review and meta-analysis of randomized controlled trials. Arch Gen Psychiat. 2007;64(4):442-55.
37. American Psychiatric Association. Practice guideline for the treatment of patients with bipolar disorder (revision). Am J Psychiatry. 2002;159(4):1-50.
38. Amsterdam JD, Shults J. Efficacy and mood conversion rate of short-term fluoxetine monotherapy of bipolar II major depressive episode. J Clin Psychopharmacol. 2010;30(3): 306-11.
39. Fountoulakis KN, Yatham L, Grunze H, Vieta E, Young A, Blier P, et al. The International College of Neuro-Psychopharmacology (CINP) treatment guidelines for BD in adults (CINP-BD-2017), part 2: review, grading of the evidence, and a precise algorithm. Int J Neuropsychopharmacol. 2017;20(2):121-79.
40. Kupka RW, Luckenbaugh DA, Post RM, Leverich GS, Nolen WA. Rapid and nonrapid cycling bipolar disorder: a meta-analysis of clinical studies. J Clin Psychiatry. 2003;64(12):1483-94.
41. Regier DA, Farmer ME, Rae DS, Locke BZ, Keith SJ, Judd LL, et al. Comorbidity of mental disorders with alcohol and other drug abuse. Results from the Epidemiologic Catchment Area (ECA) study. JAMA. 1990;264(19):2511-8.
42. Grant BF, Stinson FS, Hasin DS, Dawson DA, Chou SP, Ruan WJ, et al. Prevalence, correlates, and comorbidity of bipolar I disorder and axis I and II disorders: results from the national epidemiologic survey on alcohol and related conditions. J Clin Psychiatry. 2005;66(10):1205-15.
43. Weiss RD, Griffin ML, Kolodziej ME, Greenfield SF, Najavits LM, Daley DC, et al. A randomized trial of integrated group therapy versus group drug counseling for patients with BD and substance dependence. Am J Psychiatry. 2007;164(1):100-7.
44. Geller B, Cooper TB, Sun K, Zimerman B, Frazier J, Williams M, et al. Double-blind and placebo-controlled study of Lithium for adolescent BDs with secondary substance dependency. J Am Acad Child Adolesc Psychiatry. 1998;37(2):171-8.
45. Davis LL, Bartolucci A, Petty F. Divalproex in the treatment of bipolar depression: a placebo-controlled study. J Affect Disord. 2005;85(3):259-66.
46. Muzina DJ, Gao K, Kemp DE, Khalife S, Ganocy SJ, Chan PK, et al. Acute efficacy of Divalproex sodium versus placebo in mood stabilizer-I bipolar I or II depression: a double-blind, randomized, placebo-controlled trial. J Clin Psychiatry. 2011;72(6):813-9.
47. Gyulai L, Bowden CL, McElroy SL, Calabrese JR, Petty F, Swann AC, et al. Maintenance efficacy of Divalproex in the prevention of bipolar depression. Neuropsychopharmacology. 2003;28(7):1374-82.
48. Nery FG. Comorbid BD and substance abuse: evidence-based options. Curr Psychiatr. 2011;10(4):57-67.
49. Salloum IM, Cornelius JR, Daley DC, Kirisci L, Himmelhoch JM, Thase ME. Efficacy of valproate maintenance in patients with BD and alcoholism: a double-blind placebo-controlled study. Arch Gen Psychiatry. 2005;62(1):37-45.
50. Salloum IM, Douaihy A, Cornelius JR, Kirisci L, Kelly TM, Hayes J. Divalproex utility in BD with co-occurring cocaine dependence: a pilot study. Addict Behav. 2007;32(2):410-15.

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