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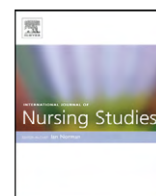

Recognising prodromes of manic or depressive recurrence in outpatients with bipolar disorder: A cross-sectional study[☆]

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ABSTRACT

Background: There is some evidence that teaching patients to recognise prodromes of manic and depressive episodes improved time to recurrence and hospitalization, social function, and performance in employment. Little information is available about which prodromal symptom patients with bipolar disorder recognise as being the very first symptom of recurrence.
Objectives: The aims of this study were to describe the very first symptoms in manic or depressive recurrence reported by patients with bipolar disorder and to explore associations between the ability to recognise these prodromal symptoms and the clinical characteristics of these patients.
Design: A cross-sectional, descriptive design.
Settings: Five psychiatric outpatient clinics in the Netherlands.
Participants: 111 outpatients diagnosed with bipolar disorder, currently not in an episode.
Methods: Data were obtained through a face-to-face interview with open ended questions and a questionnaire for demographic and clinical characteristics. Reported prodromes were categorised in an instrument inductively constructed and based on literature review and expert opinion. Associations were calculated with chi squares.
Results: The first recognised symptom of recurrence in mania was change in energy level (21%), sleep (17%), and social functioning (16%). In depression it was change in thought (15%), mood stability (12%), energy level (12%), social functioning (11%), and sleep (10%). Twenty-eight percent of the patients were not able to recognise prodromes of recurrence in mania. Also 28% was not able to recognise prodromes of depression, and 12% was not able to recognise either of them. A significant association ($p = 0.033$) was found between the ability to recognise prodromes of depression and the lifetime number of depressive episodes.
Conclusions: The majority of euthymic patients with bipolar disorder are able to recognise prodromes of recurrence. These warning signs often emerge early in the process of recurrence. Our results suggest that patients learn to recognise prodromes of recurrence rather by experience than from therapeutic interventions. Talking to patients and their relatives closely after recovered from an episode to construct the early phase of recurrence can be important to improve recognition and prevent future episodes of mania or depression.
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What is already known about the topic?

- Early prodromal symptoms are idiosyncratic to the patient and consistently develop in the weeks before manic or depressive relapse.
- About four out of five individuals with bipolar disorder can identify one or more early symptoms preceding full recurrence.
- Recognition and self-management of depressive and manic prodromes lengthen time to recurrence and hospitalization, and improve social function and performance in employment.

What this paper adds

- The very first symptom of recurrence in mania was change in energy level (21%), sleep (17%), and social functioning (16%). In depression it was change in thought (15%), mood stability (12%), energy level (12%), social functioning (11%), and sleep (10%).
- Our results suggest that patients learn to recognise prodromes of recurrence rather by experience than from therapeutic interventions.
- We present an overview of prodromal symptoms reported in the literature that can be used in clinical practice while taking to patients about their specific prodromes of recurrence.

1. Introduction

Bipolar disorder is a recurrent and long term mental illness that can seriously affect the lives of patients and their relatives. It has been ranked ninth among the worldwide causes of non-fatal disease burden for people of all ages and ranged fifth for people between 15 and 44 years of age (WHO, 2001). It is characterized by the alternating occurrence of manic, hypomanic, depressive and mixed episodes. Bipolar disorder has life time prevalence rates estimated to be 1.5–2% in the European Union (Pini et al., 2005). The prevalence rate of bipolar spectrum disorders may rise to 5% or higher with sensitive detection of hypomania (Angst and Cassano, 2005; Angst, 2007). Treatment is largely symptomatic and aimed at the prevention of subsequent episodes and, when an episode does occur, reduction of its impact to the greatest degree possible. Treatment predominantly relies on pharmacotherapy and psycho-education. In spite of these effective treatments recurrence rates for mania or depression are high (Judd et al., 2005; Kupka et al., 2007). In a recent Cochrane review (Morriss et al., 2007) it is concluded that, in addition to treatment as usual including medication and regular visits to the mental health care professional, early warning signs interventions, targeted at improving the recognition and self-management of depressive and manic prodromes, lengthen time to recurrence and hospitalization. Lam et al. (2001) define prodromes as 'any reports of change in cognitive, affective or behavioural aspects that make patients suspect they may be at an early stage of either mania or depression'. These prodromal symptoms are idiosyncratic to both the patient and to the type of episode, i.e. mania or depression (Perry et al., 1999). The early warning sign intervention as described by Perry et al. (1999) is aimed at preventing manic and depressive episodes. The intervention has two stages. The first stage is to train the patient to identify prodromal symptoms of manic and depressive episodes. The second stage is to produce an action plan to help the patient cope with these prodromes once they occur and are recognised by the patient and/or his relatives. The plan describes which actions are taken by whom once the prodromes are recognised. Using mood graphs such as the life chart methodology (Leverich and Post, 1998) can be of great help to recognise prodromal symptoms during previous episodes (Goossens et al., 2008a). In order to have more time to take action and thereby prevent recurrence, it is necessary to teach the patient to identify prodromal symptoms as early as possible in case of an impending mood episode (Russell and Browne, 2005). The use of an action plan is one of the interventions most frequently used by community psychiatric nurses in the Netherlands (Goossens et al., 2008a).

In a systematic review on manic and depressive prodromes, Jackson et al. (2003) report that four out of five individuals with unipolar or bipolar disorder can identify one or more early symptoms that precede a full recurrence. The studies included in this review reported on all the symptoms a patient may experience when becoming (hypo)manic or depressed. Sleep disturbance was the most prominent prodrome of mania, and mood change that of bipolar depression. The studies included differ greatly on sample sizes (mean $n = 40$; range 20–206) and methodology. Two studies (Lam and Wong, 1997; Molnar et al., 1988) used a semi-structured interview, and two studies (Wong and Lam, 1999; Keitner et al., 1996) used open ended questions in questionnaires, while Smith and Tarrier (1992) used a self-constructed 40 items symptom checklist, and Sclare and Creed (1990) used the present state examination (Wing et al., 1974) to asses psychiatric symptoms. After 2003 only one study on this topic was published (Mantere et al., 2008). In this study, 191 patients in an acute phase of illness were asked to report prodromes of recurrence via open ended questions. Only half of these symptomatic patients were able to report prodromes.

Little information is available about prodromal symptoms that patients recognise as being the very first sign of an impending mood episode. Two goals were therefore identified for the present study:

- To identify the first prodromal symptom of mania or depression experienced by outpatients with bipolar disorder as an early warning sign of recurrence.
- To explore the associations between the clinical characteristics of these patients and their ability to identify prodromes of manic or depressive recurrence.

2. Methods

The study reported in this paper was part of a larger study on care needs in bipolar disorder (Goossens et al., 2007), coping styles in bipolar disorder (Goossens et al., 2008b) and psychopathological symptoms and quality of life in bipolar disorder (Goossens et al., 2008c). The study was conducted at five psychiatric outpatient clinics in the Netherlands and used a cross-sectional research design.

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