Poor Practice, Managed Care, and Magic Pills: Have We Created a Mental Health Monster?

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Anyone working in the mental health field will recognize that in patients with extreme irritability, explosive behavior, or quick mood changes, bipolar disorder (BD) is often unquestionably diagnosed. Thus, it is no surprise that a recent US study indicated a 10-year 40-fold increase in BD diagnosis in pediatric patients.[1]

Three factors are largely responsible for the phenomenon described in the **Case Vignette:** poor practice, managed care, and a pill-pushing society.

Poor practice. Even though the standard of care in psychiatry is structured around standardized assessments and measurement-based practice, this may not be adhered to in community clinics, private practices, and even academic centers. In addition, residents and fellows in training may not have been exposed to structured interviewing. Clearly, this perpetuates unstructured interviewing and impressionistic diagnostic assessments in clinical settings.

Managed care. Many managed care companies do not allow those patients who are clearly a danger to self or others to be admitted to acute psychiatric units with diagnoses such as substance use disorders, conduct disorders, and intermittent explosive disorders. Combined with impressionistic diagnostic practices, this phenomenon makes BD the diagnosis of choice to get reimbursement for evaluation and treatment.

Pharmacotherapy. Rather than taking responsibility for interpersonal and family dynamics, or going through labor-intensive psychotherapeutic interventions, many parents opt for the quick fix of a BD diagnosis. A diagnosis of BD not only justifies psychopharmacological interventions, but it also arguably absolves the family of personal responsibility. The fact that managed care has led to pharmacotherapy being less expensive than intensive psychotherapy has enhanced the "McDonaldization" of mental health care.

The overdiagnosis of BD in children, adolescents, and adults has lost its utility, because it encompasses patients with "true" BD and a variety of other disorders (eg, attention-deficit/hyperactivity disorder, conduct disorder, substance use disorders, personality disorders). This state of affairs will continue until the psychiatric field and its practitioners take a strong stance for evidence-based medicine.

CASE VIGNETTE

Police have brought a 15-year-old boy with severe agitation to the emergency department (ED). He trashed his room and threatened to kill his parents. He has a long history of explosive behavior. Police are willing to drop charges if he is admitted to the hospital. The patient's parents express their concern to the ED physician that their son may have BD.

After taking a rudimentary history, the hospital admits the patient with a diagnosis of BD. The ED physician knows that the patient's managed care organization will not allow inpatient admission with a diagnosis of conduct disorder. No standardized/structured psychiatric evaluation is performed on patients admitted to the inpatient unit.

Doctors give the patient an atypical antipsychotic and discharge him. He is referred to a busy outpatient clinic, where the admitting and discharge diagnosis of BD is taken at face value, no further evaluation is done, and the patient's regimen of an atypical antipsychotic is continued. No specific psychotherapy or parent management training is instituted. The parents insist on maintaining their son's current pharmacotherapy regimen. Because of their son's diagnosis, the parents have begun the process of applying for Social Security benefits on his behalf.

Suggestions and remedies

The prime responsibility to correct this state of affairs rests on psychiatrists and the psychiatric field. At the present time, there is sufficient evidence to support structured interviewing and measurement-based practice. Several studies have shown the feasibility of these practices, even in busy community clinics.[2,3] There is sufficient evidence to show that explosiveness, mood lability, and extreme irritability do not necessarily equal BD.[4]

A 2008 study underscores the validity of structured interviewing and outcome assessments in busy community clinics.[5] The study shows a significant differential response to treatment in children with BD versus non-bipolar mood disorders characterized by extreme irritability and explosiveness. In fact, a growing line of research shows that in children with severe irritability but without core features of mania, BD does not develop in later life.[6] It is therefore paramount that the correct diagnosis is made.

A diagnosis has treatment and prognostic implications. Even though the treatment of youths with severe mood disorder without BD is currently not well researched, it is hoped that future studies will elucidate more specific treatments for these children. The consideration in DSM-5 of a new diagnostic category for youths with severe mood disorders without BD may help in this regard. The following suggestions are offered to help remedy this problem:

Structured interviewing. There are several advantages to this tool. It forces the evaluator to focus on core symptoms of specific syndromes, thereby avoiding impressionistic and incomplete assessments. The core symptoms of BD during a manic episode include developmentally inappropriate euphoria, developmentally inappropriate grandiosity, decreased need for sleep, racing thoughts and flight of ideas, and hypersexual behavior.[7] Explosiveness, anger, low frustration tolerance, and quick mood changes are not part of the core symptoms of mania.

Structured interviewing forces the evaluator to explore comorbidity, which helps in the differential diagnostic formulation. For example, the uncovering of psychotic symptoms in an extremely irritable adolescent has a totally different meaning than the uncovering of conduct disorder symptoms in the same individual.

Diagnosis-specific screening tools and rating scales. Currently, several clinician-friendly structured interviews are available. Repeated use of available diagnosis-specific rating scales as screening tools or outcome measures will help in an ongoing differential diagnostic process. The Mood Disorder Questionnaire (MDQ) and the Parent Version of the Young Mania Rating Scale (P-YMRS) are helpful tools for differentiating core manic symptoms from other severe mood-disordered symptoms.[8]

Education. Psychiatric trainees should be educated about the use of structured interviews, rating scales, and outcome measures beginning in their first postgraduate year. In our clinic, medical students rotating through the outpatient program are exposed to structured interviewing of patients and are encouraged to participate in this activity. Social work and psychology students should be trained in evidence-based psychotherapy so that diagnosis-specific psychosocial treatments can be implemented.

Psychiatric associations should do a much better job educating the public and insurance companies about what constitutes proper psychiatric practice (eg, diagnostic tools, practices, criteria).

Conclusion

Various forces have created an enormous problem with the BD diagnosis. This problem affects many patients, families, and society at large. Patients may be inappropriately treated with medications, parents may not obtain the proper treatment for their children, and society may be paying a hefty price in the form of pharmacy costs, disability costs, and Social Security benefits without proper justification.

As physicians, we need to take up our responsibility and institute state-of-the-art evaluation and treatment methods based on the best available evidence.

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