Bipolar Disorder in Italy

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The Italian National Health System

Italy is a developed European country with a population of approximately 60 million. Health care is provided to the entire population by the National Health Service (NHS). All citizens have access to unlimited health care coverage through "Local Health Units" (LHUs), each of whom manages a geographically defined catchment area. While access to some services is partially paid by the user, others are free of charge. As the administration of health services is gradually being transferred from the state to regional governments, psychiatric care may be totally free of charge in some regions, while other regions may request payment of a fee ('ticket') by citizens.

The Italian Mental Health System

After the intruction of the "Basaglia" Law or 180 Law (Italian: *Legge Basaglia, Legge 180*), the 1978 Mental Health Act containing directives for the closing down of all psychiatric hospitals, psychiatric assistance is administered by a network of 211 Mental Health Departments (MHDs), each of whom covers a geographically defined area, usually corresponding to that of a LHU. Each MHD includes: a) Community Mental Health Centers (CMHCs); b) General Hospital Psychiatry Units; c) Day Centres; d) Residential Facilities. CMHCs deliver the bulk of outpatient and non-residential care, mainly through a network of outpatient clinics. In most regions, they operate 12 h a day, 5–6 days a week, and provide individual consultations and visits, organize domiciliary care activities for the most severe patients, as well as provide emergency interventions. Hospitalisation, day care, and psychiatric rehabilitation are free of charge throughout the whole country. The majority of psychiatric drugs (e.g., antipsychotics, lithium, carbamazepine, valproic acid, tricyclic antidepressants, and SSRIs) are provided free of charge following prescription by the general practitioner or by a psychiatrist working for the National Health Service.

Definition of Bipolar Disorder

Bipolar disorder includes several symptoms and it is mainly characterized by mood instability. Changes in affective disposition are usually unpredictable, unrestrained, prolonged, and extreme, and they are commonly associated with a significant psychosocial impairment and relevant disability.
Bipolar disorder type I is characterized by episodes of major depression and mania or mixed states in which it's possible to recognize the coexistence of both depressed and manic symptoms. Bipolar disorder type II is characterized by major depression and hypomanic episodes whereas cyclothymia is a type of chronic mood disorder widely considered to be a milder or subthreshold form of bipolar disorder. In some cases, individuals may experience severe affective (e.g., psychotic) symptoms such as delusions and hallucinations. These conditions need to be closely monitored in order to prevent negative outcome and suicidality.
The concept of "bipolar spectrum", which includes in bipolar disorder milder but clinically significant syndromes and subthreshold bipolarity, has become popular in some clinical and research centre (e.g., University of Pisa), but is not so popular all over the country.

Epidemiology of Bipolar Disorder

Few studies investigate the epidemiology of bipolar disorder in Italy. Similarly to other developed countries, data reported a lifetime prevalence rates of 0,8%. It has been widely demonstrated that patients with bipolar disorder (especially bipolar disorder type I) present an early onset type of illness compared with subjects with unipolar depressive disorders. In Italy as in other countries, the mean age for the emergence of bipolar disorder type I is usually 18 years whereas 22 years has been reported as the average age for the emergence of bipolar disorder type II. However, in the last decades a drastic reduction of the mean age bipolar disorder onset has been reported presumably due to the emergent comorbidity with drug abuse in adolescence.
According to available evidence, it has been suggested that bipolar disorder is more frequent among those who are socially wealthy.

Comorbidity with other psychiatric conditions

Alcohol and other substances abuse/dependence are commonly associated with bipolar disorder. The lifetime prevalence of alcohol and other

substances abuse/dependence during the course of bipolar disorder may be greater than 30%.
Substance abuse represents a significant predictor of unfavorable outcome, symptoms instability, reduced response to treatment, chronicity, and significant disability. Patients who have a bipolar disorder in comorbidity with substance abuse usually represent a subgroup of subjects with a higher severity of the illness and reduced response to psychoactive medications. Treatment is predominantly aimed to reduce the negative impact related to the illness as well as to improve psychosocial impairment treating both bipolar condition and substance abuse/dependence.
Also, based on available evidence high percentages (40-50%) of lifetime anxiety disorders (especially panic and obsessive-compulsive disorders) have been reported in comorbidity with bipolar disorder. This comorbidity seems to be more common among women and more frequently associated with rapid cycling course and dysphoric mania.

The diagnosis of Bipolar Disorder
It has been estimated that the diagnosis of bipolar disorder in Italy as worldwide is usually performed with a mean delay of about ten years; bipolar subjects usually take during this period inappropriate treatment that are active on psychopathological not specific symptoms. More than half of patients with bipolar disorder reported having received more than three previous psychiatric diagnoses: the diagnostic delay is a more pronounced issue in women with bipolar disorder type II than in men.
One of the most important reasons regarding the mean delay in diagnosing bipolar disorder in Italy as elsewhere is typically related to the different clinical presentations of this disease and to the fact that only a part of the clinical history is mentioned by bipolar patients who may frequently denied to be ill.

How to treat Bipolar Disorder
Pharmacological approach represents a fundamental option in the treatment of patients with bipolar disorder.
The best treatment strategy aimed to reduce the number, duration, and severity of affective episodes, ensuring euthymia and restoring psychosocial functioning. People affected by bipolar disorder (especially type I) are usually treated by Community Mental Health Services in Italy.

Pharmacological treatment is provided according to the common international guidelines.

Psychoactive drugs used to treat manic episodes

The common psychoactive medications used to treat manic episodes are mood stabilizers and anticonvulsant drugs. Mood stabilizers may be considered the first-line treatment during manic, hypomanic or mixed episodes of bipolar disorder:

1) Lithium. Lithium is the best pharmacological option to treat acute mania in subjects with bipolar disorder. In particular, lithium is effective to prevent mania and treat mild to moderate manic episodes after their emergence. However, as mentioned the diagnosis of bipolar disorder in Italy is usually delayed largely due to the more frequent diagnosis of unipolar disorders and the indiscriminate use of other compounds such as antidepressant drugs. The use of the slow-release lithium clinically associated with lower dropout rates is not so common in Italy whereas the quick-release formulation is more frequently used.

2) Sodium valproate. Sodium valproate is one of the most used drugs in monotherapy or add-on therapy to other mood stabilizers among all psychoactive medications used to treat manic episodes. It has been reported that sodium valproate is more effective than other anticonvulsants on rapid cycling forms.

3) Other anticonvulsants. The clinical use of certain drugs mainly used as antiepileptic medications (e.g., carbamazepine, oxcarbazepine, lamotrigine, gabapentin, topiramate) significantly contributed to the pharmacotherapy of major psychopathological disorders, in particular, to those including within the affective spectrum. However, most of these antiepileptic drugs have not yet been indicated as mood stabilizers.

4) Antipsychotics. First or second-generation antipsychotic medications may be used in the treatment of acute manic/mixed episodes in association with mood stabilizers offering advantages particularly related to the lower latency of response.

Psychoactive drugs used to treat depressive episodes

It is widely recognized that the treatment of depressive episodes using antidepressant drugs in monotherapy without using any mood stabilizing drugs may induce manic switch, rapid cycling, and instability of the course of the disease. Antidepressant medications should be considered as drugs having stimulant properties that may enhance mood instability. The use of antidepressants should be usually considered together with mood stabilizers (never alone) in the treatment of bipolar disorder.

1) Antidepressants. Antidepressant drugs are commonly used in Italy to treat depressive episodes of bipolar illness but the indiscriminate use of psychoactive compounds having antidepressant properties may increase the instability of the illness. To date, there is no evidence showing that antidepressant drugs really add stabilizing effects to the long-term treatment of bipolar disorder.

2) Lamotrigine. Lamotrigine has been suggested to have antidepressant affects in subjects with bipolar disorder. Specifically, lamotrigine has been recognized to prevent depressive recurrences in patients with bipolar disorder.

3) Antipsychotics. Some second-generation (e.g., olanzapine, aripiprazole) antipsychotics can be used in the treatment of acute episodes in association with mood stabilizers offering advantages particularly related to the lower latency of response.

Psychotherapy to treat bipolar disorder

Cognitive-behavioural therapy

Psychotherapy may be successfully used to integrate, but not replace, pharmacological approach. Cognitive-behavioural therapy is commonly used in bipolar disorder and is aimed to enhance patients understanding of their functioning improving the management of stress, and reduce the recurrences of this illness.

Psychoeducation

Also, as poor adherence to treatment in bipolar patients has been reported as one of the most important reason associated with the inadequate treatment, psychoeducation is aimed to enhance patients' knowledge and

information about the main characteristics of the illness. Psychoeducation is also aimed to reduce the number/severity of the illness episodes as well as the overall rate of hospitalizations.
Psychoeducation is usually provided individually by psychiatrists, psychologists, nurses, although few psychiatric services (mostly in northern Italy) deal with psychoeducational groups. Patients affected by less severe types of bipolar disorder (especially type II), if they can afford, can also choose a private treatment. The price for a private psychiatric consultation is usually 80-150 Euro, and 60-100 Euro for a psychotherapy session.

The impact of stigma in patients with bipolar disorder

The impact of stigmatization is multifaced and includes discouraging individuals from seeking help through fear of being labeled and/or embarrassed, leading to reduction of self-esteem, premature termination of treatment and social isolation.
Stigma on mental illness remains a dramatic problem in Italy as high levels of perceived discrimination were commonly reported among patients with psychiatric disorder, in particular major affective disorders. It has been reported that alienation, social withdrawal, and discrimination may be frequently experienced by patients with bipolar disorder. Based on initial multicenter studies, subjects with bipolar disorder experience less self-stigma (defined as accepting diminished expectations or applying stereotypes to oneself) when compared to those with schizophrenia or depression.
However, the cross-cultural nature of most studies and the fact that findings from multicenter studies were not usually weighted to take account of country size (samples that may be not representative of the reference population), represent important limitations to provide evidence on the levels of stigma in patients with bipolar disorder.

Self help resources

http://www.bipolari.it
http://www.sfidabipolare.net/

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