

Recognising the relevance of cognitive dysfunction in the clinical management of bipolar disorder

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The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is to be commended for setting forth clear and detailed directions regarding the management of bipolar disorder's (BD) mood symptomatology and episode recurrence in its 2020 clinical practice guidelines (1). We were surprised however, that cognitive dysfunction was only briefly mentioned as an aspect of BD's symptom profile (in the context of the ACE model). However, increasing international consensus exists regarding the need to assess and address cognitive dysfunction in the long-term clinical care of BD, given the negative impact of cognitive dysfunction on illness prognosis and everyday functioning (2) .

Whilst long recognised by clinicians as a component of BD's defining mood episodes, increasing empirical data shows that cognitive dysfunction persists even beyond the resolution of acute mood symptoms (3). Several studies indicate that cognitive dysfunction is present in 40-60% of BD patients, and contributes to the psychosocial difficulties that persist in BD even after clinical stabilisation (3). There is also empirical data to show that cognitive dysfunction may progressively worsen alongside increasing illness length or severity, at least in some people (3). However, the temporal nature of such interactions is unclear, and it is very possible that the relationship is bidirectional. Not only may clinical worsening result in cognitive dysfunction, but cognitive dysfunction may also drive the emotional dysregulation that results in clinical worsening (3). These data together suggest that cognitive dysfunction should be recognised as both a core feature and an important consideration in the long-term care of people with BD, particularly given the possibility that it may represent a key limiting factor in a patient's capacity to maintain stable mood and mitigate relapse.

In our experience, cognitive dysfunction outside of mood episodes is not necessarily acknowledged, nor given due credence in terms of its consequences, by clinical practitioners

working with people with BD. This oversight may impede the therapeutic relationship by misaligning expectations on the part of the patient and the clinician. Hence, awareness that there is potential for sustained cognitive dysfunction in patients with BD is important, and should be considered by clinicians when setting tasks, examining cognitive biases, and in interacting with patients generally. Acknowledgment of the potential for cognitive dysfunction and its suspected catalysts during the remitted phase of BD will also help to aid awareness of the issue and facilitate education of patients and families. This can promote empathy, reduce stigma, provide an impetus for the implementation of a more healthy lifestyle, and even potentially lessen medication non-compliance since patients tend to view medication as the primary source of their cognitive difficulties when this may not be the case (4).

Recently, the ISBD Targeting Cognition expert taskforce recommended that *objective* cognitive screening assessments should be carried out for *all* clinically stable adult BD patients (2). The taskforce also recommended some brief, validated cognition screening tools - the SCIP (Screen for Cognitive Impairment in Psychiatry) and COBRA (Cognitive Complaints in Bipolar Disorder Rating Assessment), that are freely available from the ISBD website (<https://www.isbd.org/cognitive-assessment>). Whilst there are currently no treatments indicated specifically for cognitive dysfunction in BD because pro-cognitive therapies are only just beginning to be tested (5), detection of cognitive impairments through screening can still facilitate the clinical management of BD in several ways. These include indicating a) when a detailed diagnostic evaluation is needed if there is concern about organic brain illness or rapid cognitive decline, b) that there may be secondary causes for cognitive dysfunction, such as comorbid drug or substantial alcohol use or medical illness, that should be addressed, c) that medication regimes may be adversely impacting cognition and need

optimisation to reduce cognitive symptoms, d) that good habits, including regular sleep and exercise, may be helpful, and/or e) that patients may need to make adjustments to their social and occupational circumstances to accommodate their cognitive dysfunction (2). For example, formal detection of cognitive dysfunction will bring about awareness, and thus opportunities for patients to implement compensatory techniques to cope with cognitive difficulties; which will help maintain occupational, educational and interpersonal functioning and thereby contribute to quality of life. This would be essential for them to build up their cognitive reserve by engaging in education and vocational activities, which will likely increase their resilience and prognosis long-term.

In sum, assessment and management of cognitive dysfunction in BD should be explicitly included in future directions for the management of BD. Cognitive dysfunction exists in a large proportion of patients, including during remission, and hampers patients' daily functioning and may directly contribute to mood dysregulation. Improving screening, awareness and treatments for cognitive dysfunction therefore represents an essential step toward better treatments that do not only improve the course of illness but also patients' daily functioning and quality of life.

References

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