Ongoing Management of bipolar disorder

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Abstract

Bipolar (affective) disorder is a challenging psychiatric illness to manage and is associated with significant risk of morbidity and mortality. A meta-analysis has revealed that suicide is 20 times higher in patients with bipolar than the general population (7). Acute relapses of bipolar are often managed in secondary care with hospitalisation whereas long-term maintenance management is achieved largely in primary care. This paper discusses the ways in which lifestyle, psychotherapy and pharmacotherapy can be utilised in maintenance management, how they are advantageous in patients and what obstacles are faced.

Key words: bipolar disorder, maintenance management, pharmacotherapy, psychotherapy, lifestyle management, non-compliance, monitoring bipolar, primary care.

Introduction

Bipolar (affective) disorder is considered one of the most challenging psychiatric conditions to manage due to its characteristic fluctuations of mood and chronic relapsing and remitting course. The prevalence of bipolar I and II disorder varies from 0.4-0.6% and 0.5% respectively (1). Equal ratios of males and females are diagnosed with bipolar I in opposition to a higher ratio of females diagnosed in Bipolar II (1). Presentation of bipolar is often also different between the sexes; males predominantly present with a manic episode on first presentations whereas females often present with depression (1).

Bipolar disorder is usually treated acutely by specialist psychiatric services, leaving primary care to manage the condition long-term. Although it has been associated with the ability to display impressive creativity in some patients, it has also had a negative impact on the lives of most patients. Greater than 4% of women and 7% of men die through suicide attempts within two decades of diagnosis (2). Studies have also shown that untreated illness for prolonged periods can provoke poor response to treatment, poor social adjustment, higher hospitalisation rates and development of comorbidities (3, 4). Appropriate long-term management is therefore crucial as episodes become more frequent and difficult to treat in both types (3). These multiple implications of bipolar disorder make it imperative that it is diagnosed correctly and managed appropriately. Good management can prevent major disruption and morbidity in the lives of patients. However, one of the biggest challenges facing bipolar treatment is the lack of patient compliance. It has been reported that patients experience symptoms 47% of their life, more so in depressive states (29). Moreover, only 40% of patients comply with drug treatments one year following an episode (30).

Non-compliance in maintenance of bipolar disorder

Despite the morbidity associated with bipolar disorder, long-term treatment, which almost always involves medication, does not make it easy for a patient to comply with maintenance treatment and the unfavourable side effects of medication. A study conducted to assess adherence by collection of prescriptions suggested that only 54.1% were fully adherent to maintenance drugs, 24.5% were partially adherent whereas another 21.4% were not adherent (22). Non-adherent individuals were more likely to be homeless, young in age, unmarried, non-caucasian or have a substance use disorder; they attended fewer outpatient psychiatry visits (22). In addition it was found that those on combination therapies had better adherence than those given prescriptions for monotherapy (22). Unfavourable side-effect profiles of popularly prescribed mood stabilisers, e.g lithium (which requires meticulous monitoring) and antipsychotics, e.g. olanzapine (weight gain) significantly contribute to non-compliance and require regular review.

Treatment Options

The core objectives of treating patients with bipolar disorder include: reduction of symptoms and risk, stabilisation of mood and prevention of relapse (9). In addition, patients should be educated with awareness into their mental health. Aims of education are directed towards identifying coping strategies and enabling them to consult for advice as early as possible, when needed. Despite significant developments in pharmacological management of bipolar disorder, most patients are unable to recover using drug treatments alone (28). Three forms of treatment have been developed to incorporate all of these objectives and should be implemented collectively. These include lifestyle modification, psychotherapy and pharmacology. Risks of suicide are shown to be lower when patients are satisfied with their level of care, are treated for alcohol and tobacco abuse and take lithium (6, 7, 8). This illustrates the combined importance of lifestyle modification, psychotherapy and pharmacology in managing patients. In ideal circumstances the patient should feel they are able to live their lives as normally as possible with support from primary and secondary mental health teams (5).

Lifestyle management, psychotherapy and community care

Psychosocial stress is known to instigate symptoms of mania and depression. Psychotherapy can go hand in hand with pharmacotherapy and lifestyle management to identify early warning signs and patient awareness into their own mental health. This can reduce relapse rates, frequency of hospitalisations and improve social functioning (6, 27,31,32). Rates of relapse average between 40-60% in 1-2 years, despite being treated with pharmacotherapy (11). It is therefore important that psychotherapy is used as an adjunct to pharmacotherapy. Psychological support should be provided to patients with bipolar disorder in the form of psychotherapy for at least 16 sessions over a period of six to nine months. This enables exploration of management and coping strategies such as the recognition of changing mood and its triggers. The patient should be assigned a care co-ordinator in the community who will conduct weekly visits for 6 months to support them until their condition has stabilised. Management, progress and coping strategies can be discussed with the care co-ordinator to ensure optimal advancement in their mental health. The patient should also be informed of self-help and bipolar groups. Through these, they can share their experiences with patients who have a similar diagnosis, enabling them to feel more supported and achieving greater insight into their condition. It has been shown that patients who undergo intensive psychotherapy (6) or group therapy (27) are less likely to relapse and have longer spells of 'wellness' compared to those who have had only brief therapy. Moreover, those who have more manic symptoms are more likely to improve with strategies to promote medication adherence and early recognition of symptoms; whereas those with depressive symptoms are more likely to improve with CBT and interpersonal coping strategies (9, 28). With the help of the patient's family, carers and care co-ordinator, identification of suicidal or homicidal ideation should be addressed immediately and promptly managed (9).

Lifestyle adjustments can also help prevent triggers of relapse. NICE guidelines have suggested good sleep hygiene, relaxation techniques and avoidance of excessive stimulation (5). Sleep is particularly important, as sleep deprivation can potentiate manic episodes. Overnight shift work is discouraged.

Maintenance pharmacotherapy

The prognosis of bipolar disorder is dependent upon early diagnosis and treatment. This reduces the risk of relapse and doubles the response rate of medications (9, 26). Indefinite treatment (once appropriate mood stabilisers have been identified) should continue because of the risk of relapse. A study by one group suggested that relapse can occur in one third of patients in the first year following presentation, and in more than 70% within 5 years in patients that are not treated (11). Psychiatrist involvement is often requisite in management of patients, due to psychiatric comorbidities, treatment resistance, relapse and risks of harm to themselves and others (9). Women who require treatment must be educated about teratogenic side-effects of mood stabilisers and the importance of contraception whilst taking them (9). Antidepressant monotherapy carries a risk of cycle acceleration,

treatment related mania, and hypomania (12, 13); it is not recommended. Co-administration of a mood-stabilising agent with antidepressants has been shown to decrease cycle acceleration and treatment-emergent mania (13, 15, 16). Despite this research, risk is not completely eliminated and hence antidepressants should only be used with mood stabilisers and only for the time when the patient is depressed, whereas mood stabilisers should be used throughout every phase of the illness, including when the patient is euthymic (17, 18).

NICE has published recommendations for long-term treatment based upon the type of bipolar disorder and number of presentations. They advise maintenance treatment in bipolar I patients following two acute episodes, or a single severe episode with consequences (5). They also suggest prophylactic treatment in patients with bipolar II disorder who relapse frequently, have functional impairment or are at risk of suicide (5). Choice of prophylactic drug (s) is often dictated by the leading pattern of relapse (25). Use of lithium, lamotrigine, valproate, quetiapine and olanzapine has been supported well by particular studies for bipolar disorder (9, 19-21). However, combinations of quetiapine with lithium or valproate are considered more effective than using either of the latter in isolation (9, 19). Each medication possesses its own specific side effects, which may make one medication favourable over another. Lithium, for example, is associated with a low therapeutic index and requires three-monthly blood tests for serum lithium concentrations, as well as six-monthly thyroid and renal function blood tests (25). Rapid withdrawal can induce relapses and it must therefore be stopped gradually when a decision is made to end treatment (25). All of this needs to be discussed with the patient so they have a clear awareness of when to seek help, and how to manage their medications in the best way.

Non-prescribed medications have also shown benefit in maintenance therapies. Omega-3 fatty acids can help aid reduction of depressive symptoms in patients with bipolar disorder via similar mechanisms to lithium and valproate (9, 23). Lifestyle modifications can also be adopted to combat adverse effects of medications. A randomized controlled study showed that a moderate exercise program with active management of body weight improved weight loss and lipid profiles in patients taking olanzapine compared to controls (24). Such strategies can be advised in clinics when starting patients on a particular therapy.

Monitoring bipolar disorder

Regular clinical examination and assessment of physical health is recommended (9). Bipolar disorder is associated with higher rates of general medical comorbidities. These include diabetes, cardiovascular disease and obesity (compared to age-matched individuals) (34). Bipolar disorder is also associated with higher risks of cardiovascular disease than other psychiatric diagnoses (9, 34). Assessment of depressive, manic and sleep symptoms, suicidal risk, comorbidities and substance abuse must be conducted frequently to alert the services of any changes in mental state (9). The weight and lipid profile should be consistently assessed, particularly in those taking antipsychotic medications such as olanzapine, risperidone or quetiapine, due to alterations in metabolism. Antipsychotics have been said to accelerate cardiometabolic risk accumulation, thereby contributing to premature death rates (35). These factors must be monitored closely, particularly in those with co-existent general medical morbidities. Other adverse effects frequently associated with antipsychotics include extrapyramidal symptoms (akathisia, parkinsonism, and other movement disorders such as dystonias and dyskinesias). Tardive dyskinesia can occur within months of initiation and is potentially irreversible, particularly affecting those that are elderly with cardiovascular disease, stroke or neurological vulnerability (9). Symptoms should be monitored using the Abnormal Involuntary Movement Scale during follow-up visits (9).

Selection of medications and dosage adjustments should always be explored during each follow-up visit, to ensure patients are not skewing to a manic, hypomanic or depressive episode. Lower doses may be indicated in children, underweight patients, the elderly and those with chronic disease (9). Higher doses may be required for those who are severely psychotic (9, 10).

Conclusion

Bipolar disorder remains a debilitating psychological disorder associated with significant risk of morbidity and mortality. It has one of the highest suicide rates among all psychiatric diagnoses; one third of patients attempt suicide (33). Prophylactic treatment is mostly administered in the primary care sector and is fundamental in preventing relapses. Bipolar disorder can be managed using lifestyle changes, psychotherapy and pharmacotherapy in order to prevent relapse, reduce risk and stabilise mood. An educated awareness of bipolar disorder can also help identify any symptoms early so they can be suitably treated. Doses of medications must always be monitored and enquiry should always be made about possible adverse effects. Regular blood checks and physical examinations will also assist in identifying any adverse reactions. Although bipolar disorder is associated with significant morbidity, if it is managed well, many patients respond successfully to treatment and live a full life.

GP Comment

What have I learned from this paper?

This paper helped me to refresh my knowledge on bipolar disorders at a time when many of us in primary care find it difficult to distinguish bipolar from general mood swings.

It was also interesting to see the evidence behind effectiveness of using lifestyle and psychotherapeutic interventions in reducing relapses in bipolar disorder.
This evidence will encourage me to use such therapies in my own practice.
Altogether I think the paper was well balanced in providing information required by the general practitioner.

Dr Roshan Jayalath, GP.

References

1. American Psychiatric Association . Diagnostic and Statistical Manual of Mental Disorders 1994.
2. Nordentoft M, Mortensen PB, Pedersen CB. Absolute risk of suicide after first hospital contact in mental disorder. Arch Gen Psychiatry2011;68:1058-64
3. Morselli PL, Elgie R; GAMIAN-Europe. GAMIAN-Europe/BEAM survey I--global analysis of a patient questionnaire circulated to 3450 members of 12 European advocacy groups operating in the field of mood disorders. Bipolar Disord. 2003 Aug;5 (4):265-78.
4. Vazquez-Barquero JL, Artal J, Caballero-Martinez P. FC3A Early Intervention In Bipolar Disorders: Rationale for the overdue implementation of a Feasible Paradigm. Schizophrenia Research 2006 ;86;S3-S37.
5. NICE guidelines: The management of bipolar disorder in adults, children and adolescents, in primary and secondary care CG38 (2003)
6. Parikh SV, LeBlanc SR, Ovanessian MM. Advancing bipolar disorder: key lessons from the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD). Can J Psychiatry. 2010;55 (3): 136-143
7. Novick DM, Swartz HA, Frank E. Suicide attempts in bipolar I and bipolar II disorder: a review and meta-analysis of the evidence. Bipolar Disord. 2010;12 (1):1-9.
8. Ostacher MJ, Lebeau RT, Perlis RH, et al. Cigarette smoking is associated with suicidality in bipolar disorder. Bipolar Disord. 2009;11 (7):766-771.
9. Price AL, Marzani-Nizzen GR. Bipolar Disorders: A Review. American Family Physician; 2012; 85 (5): 483-493
10. Gardner DM, Murphy AL, O'Donnell H, et al. International consensus study of antipsychotic dosing. Am J Psychiatry. 2010;167 (6):686-693.
11. Gitlin MJ, Swendsen J, Heller TL, Hammen C. Relapse and impairment in bipolar disorder. Am J Psychiatry. 1995;152 (11):1635-1640.
12. Altshuler LL, Post RM, Leverich GS et al. Antidepressant-induced manic and cyclic acceleration : a

controversy revisited. Am J Psychiatry 1995; 152: 1130- 1138
13. Goldberg JF, Truman CJ. Antidepressant-induced mania: an overview of current controversies. Bipolar Disord 2003; 5: 407-420
14. Suppes T, Kelly DI, Perla JM. Challenges in the Management of Bipolar Depression. J Clin Psychiatry 2005; 66 (suppl 5) 11- 16
15. Baldessarini RJ Tondo L, Hennen J et al. Is lithium still worth using ? an update of selected recent research. Harv Rev Psychiatry 2002; 10: 59-75
16. Thase ME Sachs GS. Bipolar depression: pharmacotherapy and related therapeutic strategies. Biol Psychiatry 2000; 48: 558-572
17. Ghaemi SN, Sachs GS, Goodwin FK. What is to be done? Controversies in the diagnosis and treatment of manic-depressive illness. World J Biol Psychiatry 2000: 1; 65-74
18. Grunze H. Re-evaluating therapies for bipolar depression. J Clin Psychiatry 2005; 66 (suppl 5) : 17-25
19. Yatham LN, Kennedy SH, Schaffer A, et al.; Canadian Network for Mood and Anxiety Treatments (CANMAT) and International Society for Bipolar Disorders (ISBD) collaborative update of CANMAT guidelines for the management of patients with bipolar disorder: update 2009. Bipolar Disord. 2009;11 (3):225-255.
20. Burgess S, Geddes J, Hawton K, et al. Lithium for maintenance treatment of mood disorders. Cochrane Database Syst Rev. 2001; (3):CD003013.
21. Cipriani A, Rendell JM, Geddes J. Olanzapine in long-term treatment for bipolar disorder. Cochrane Database Syst Rev. 2009; (1):CD004367.
22. Sajatovic M, Valenstein M, Blow F et al. Treatment adherence with lithium and anticonvulsant medications among patients with bipolar disorder. Psychiatr Serv 2007;58:855-63.
23. Stoll AL, Severus WE, Freeman MP, et al. Omega 3 fatty acids in bipolar disorder: a preliminary double-blind, placebo-controlled trial. Arch Gen Psychiatry. 1999;56 (5):407-412.
24. Milano W, Grillo F, Del Mastro A, et al. Appropriate intervention strategies for weight gain induced by olanzapine: a randomized controlled study. Adv Ther. 2007;24 (1):123-134.
25. Anderson IM, Haddad PM, Scott J. Bipolar Disorder. BMJ Jan 2013 (346): 27-32
26. Berk M, Brnabic A, Dodd S, et al. Does stage of illness impact treatment response in bipolar disorder? Empirical treatment data and their implication for the staging model and early intervention. Bipolar Disord. 2011;13 (1):87-98.
27. Castle D, White C, Chamberlain J, et al. Group-based psychosocial intervention for bipolar disorder: randomised controlled trial. Br J Psychiatry. 2010;196 (5):383-388.
28. Miklowitz DJ. Adjunctive psychotherapy for bipolar disorder: state of the evidence. Am J Psychiatry. 2008;165 (11):1408-1419.
29. Judd LL, Akiskal HS, Schettler PJ et al: The long-term natural history of the weekly symptomatic status of bipolar I disorder. Arch Gen Psychiatry 2002; 59:530–537
30. Colom F, Vieta E, Tacchi MJ et al.: Identifying and improving non-adherence in bipolar disorders. Bipolar Disord 2005; 7:24–31
31. Sullivan AE, Miklowitz DJ. Family functioning among adolescents with bipolar disorder. J Fam Psychol. 2010;24 (1):60-67.
32. Morriss RK, Faizal MA, Jones AP et al. Interventions for helping people recognise early signs of recurrence in bipolar disorder. Cochrane Database Syst Rev. 2007; (1):CD004854.
33. Cassidy F. Risk factors of attempted suicide in bipolar disorder. Suicide Life Threat Behav. 2011;41 (1):6-11.
34. Fiedorowicz JG, Solomon DA, Endicott J, et al. Manic/hypomanic symptom burden and cardiovascular mortality in bipolar disorder. Psychosom Med. 2009;71 (6):598-606.
35. Stahl SM, Mignon L, Meyer JM. Which comes first: atypical antipsychotic treatment or cardiometabolic risk? Acta Psychiatr Scand. 2009 March;119 (3):171-9