Bipolar Affective Disorder and Anxiety

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Abstract

Bipolar affective disorder (BPD) frequently occurs with comorbid mental health problems. It has been shown that the prevalence of comorbid BPD and anxiety symptoms is especially high. This is important because, for a person affected by both BPD and anxiety, there is a negative impact on the symptoms, treatment response and recovery. A clinician faces particular treatment challenges when managing these comorbid conditions due to a limited evidence base for effective interventions. The frequent occurrence of anxiety symptoms and BPD together has informed theories of the shared aetiology of these conditions.

Keywords: bipolar, anxiety

BPD and Anxiety

Psychiatric comorbidity is a well recognised phenomenon; up to 14% of those with a psychiatric disorder will actually have three or more psychiatric comorbidities (1). Anxiety disorders are frequently seen as comorbid conditions (2). For those with BPD this is a specific concern because there is up to 93% lifetime risk (3) and 32% current risk (4) of comorbid anxiety. Those individuals with BPD who are more at risk of a comorbid anxiety disorder are those with depressive tendencies (5, 6) and those for whom a depressive episode was the initial mood disturbance of their illness (7). Those with comorbid generalised anxiety disorder or social phobia more likely to have worse outcomes than those with other anxiety disorders (8).
Although comorbid anxiety with BPD is highly prevalent and the clinical sub-population most at risk is recognised, these anxiety symptoms are under-reported and, more important, under-treated (9). This is especially concerning given the negative impact that this will have on the individual.

Effect of comorbid BPD and anxiety on a patient's experience

Having comorbid BPD and anxiety can adversely affect the patient's experience of BPD. It is related to a more challenging illness course, with an earlier age of onset of symptoms of both the BPD and anxiety disorder (10, 11), a higher number of mood episodes (7) and with rapid mood switching (12). It is also associated with a longer time to remission of BPD (13) and more severe psychopathology (14). Generally a person with both BPD and anxiety will have lower functioning as scored on the Global Assessment of Functioning Scale (GAF) (15) and diminished role functioning (4).
It is particularly important that the risk of suicidality is recognised; there are higher levels of suicidal ideation in this population (16-18) and there is a "dose-response" relationship between the comorbid anxiety symptoms and suicide attempts (19). There is a specific need for improved clinical monitoring in this population (20).

The treatment of these conditions together is challenging; patients are more likely to be on a greater number of medications and will therefore also be exposed to a higher risk of more severe adverse effects (21). There is some evidence that comorbid anxiety reduces the response of BPD symptoms to antiepileptic therapies (5). Treatment is further complicated by the fact that additional comorbidities are often found in those already with a comorbid anxiety disorder e.g. substance abuse (11, 14), alcohol abuse (16, 22) and eating disorders (7).

Treatment

The difficulties of choosing effective treatment options for BPD when an anxiety disorder is also

present are compounded by the fact that effective medications for anxiety (e.g. antidepressants) often have a negative effect on BPD symptoms (23). To avoid the need for antidepressants a good choice would be an antimanic agent that also has anxiolytic properties e.g. sodium valproate , antipsychotics or anxiolytics that do not induce mania e.g. gabapentin and benzodiazepines (except alprazolam) (24). Specific antipsychotics that have some evidence for benefit in BPD are quetiapine, aripiprazole, risperidone and ziprasidone (25).

There is a wealth of evidence for psychological interventions successfully alleviating anxiety symptoms (26) and there is evidence that psychological therapy can be a useful adjunct to medications for bipolar treatment (27). These management strategies reduce the need for pharmacological input and there is an association between improved awareness of symptoms (28) and better insight (29) for this population (those who have both BPD and anxiety), suggesting that they would be good targets for psychological interventions (30). Although there is not very much evidence specifically for BPD and anxiety, the addition of mindfulness-based cognitive therapy to treatment as usual in BPD has been shown to help the anxiety symptoms (31); further research in this area is warranted and feasible (32).

Aetiology

A number of observations have led to the postulation that BPD and anxiety may have an overlapping aetiology. First, that they occur so frequently together. Second, that treatment of anxiety disorders (panic disorder or social anxiety) can trigger a hypomanic or manic episode (33, 34). Third, that adolescents with anxiety are more likely to develop BPD and those with BPD are more likely to develop anxiety (35).

Familial studies have also supported this relationship. There is an inherited risk of BPD and anxiety symptoms which could reveal a shared genetic aetiology (36, 37). There is also a low prevalence of panic attacks (anxiety symptoms) in families with no affective disorders (38). Linkage studies have previously implicated chromosome 18 as a particular focus of this shared aetiology, with highest linkages of loci in families of probands (those with BPD) with panic disorder and lowest for those without panic attacks (39). Other genetic studies have added weight to suggestions that some anxiety symptoms (e.g. panic disorder) may be a subtype of BPD with COMT and 5–HTT polymorphisms having a particular role (40).

BPD and anxiety disorders could be seen as symptoms on the same affective continuum (32). For example, those with social phobia could be a subset of bipolar patients who sit on the scale of inhibitory restraint vs. disinhibited mania (33) or those with panic disorder a subset of patients whom exhibit symptoms that could be described as dysphoric manic/mixed hypomanic states (41).

Conclusion

The combination of comorbid BPD and anxiety poses difficulties for both the patient and clinician. Because it is a common comorbidity, patients with BPD should be routinely screened for anxiety; indeed, conversely when treating a person with anxiety, the possibility of comorbid BPD should be considered. There is limited evidence on how best to manage these conditions together. Options include choosing a mood stabiliser with anxiolytic effects, using an anxiolytic antipsychotic with a mood-stabilising effect and avoiding SSRIs when possible. Although effective psychological interventions are likely to yield improvement of symptoms, further research into this is warranted. An improved understanding of the reasons for the overlapping or shared aetiology might lead to improved treatment choices for the individual.

GP Comment

What have I learned from this paper?

This article highlights the high prevalence of anxiety symptoms amongst patients with bipolar affective disorder and their association with a more challenging illness course and increased suicidality. It is recommended that we screen for symptoms of anxiety amongst patients with bipolar disorder and that these patients are managed with a mood stabiliser with anxiolytic effects, thereby avoiding SSRI's when possible. More investigation is needed into the impact of psychological interventions in this patient group.

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