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Bipolar Disorder

Bipolar disorder is also known as manic-depressive illness. It is one of the most common, severe, and persistent mental illnesses. Bipolar disorder is characterised by periods of deep, prolonged, and profound depression that alternate with periods of an excessively elevated and/or irritable mood known as mania*. Many people refer to the manic phase as a "high". Put simply, bi-polar disease is characterised by periods of highs and lows. Between these highs and lows, patients usually experience periods of normal mood and can lead a normal life. Bipolar disorder can be a lifelong struggle and challenge.

*In this article, I will regularly refer to mania; mania is the high or elevated mood a person can experience with bipolar disorder.

There has been great progress in the understanding, treatment and prevention of bipolar disorder in recent years. With advances in psychiatric support services and medication, people suffering from bipolar disorder can lead a normal and active life. As a pharmacist, I see many people who have their condition under control with the help of healthcare professionals and the support of family and friends. My aim with this article is to help improve understanding of the condition, and show how it can be successfully treated and kept under control. A more detailed version of this article is available in Whelehans along with references of studies done on bipolar disorder.

People who suffered from Bipolar

Many famous and talented people have suffered from bipolar disorder. Examples include actors Jim Carey, Ben Stiller, Spike Milligan, Robin Williams, Jean Claude Van Dame, Robert Downey Jnr; the composer Beethoven; film directors Tim Burton and Francis Ford Coppola; musicians Jimi Hendrix, Peter Gabriel, Sting, Axl Rose and Sinead O'Connor and former British Prime Minister Winston Churchill and American President Theodore Roosevelt. The list goes on. It proves that having bipolar does not prevent you having a fulfilled and productive life.

Stigma

According to a survey called 'Thinking Ahead', carried out by the World Federation for Mental Health in 2005, the majority of people with bipolar disorder believe that the public are unaware of and do not understand the condition. As a result, as many as one in four do not tell family or friends they have it for fear of social stigma. It involved almost 700 people with bipolar disorder across seven countries.

Causes

There is a genetic link for bi-polar disorder. Having a first cousin with bi-polar disease gives a 7 times increased risk of bi-polar. Children who have a parent with bipolar disorder have a 50% chance of having another major psychiatric disorder. However, despite numerous studies, the exact cause of bi-polar disorder has not been found. The cause is thought to be a combination of genetic and environmental factors (increased stress, alcohol or drug abuse).

Types

The two main types of bi-polar disease are bipolar I and bipolar II. Bipolar I disorder is also known classic manic-depression, characterised by polar opposites, episodes of major depression contrasting greatly with episodes of mania. Psychotic symptoms are more common with Bipolar I disorder. Psychotic symptoms are the loss of the concept of reality and can include hallucinations, delusions and paranoia. In comparison, bipolar II disorder is a milder disorder consisting of depression alternating with periods of less severe mania.

In bipolar II disorder, the mania phase does not include psychotic symptoms. Bi-polar II impacts less on the personôs life than bi-polar I.

How common is bipolar disease

Internationally, 0.3 to 1.5% of the population suffer from lifelong bi-polar disorder. Almost 40,000 people in Ireland have the condition. The true extent of bipolar disorder is uncertain; the diagnosis is likely to be missed when people are seen with depression and not asked about symptoms suggesting prior episodes of mania.

Characteristics of sufferers

Age of onset
The age of onset is generally between 15 and 30 year. Newly diagnosed mania is uncommon in children and in adults over the age of 65.

Race
Bi-polar disorder occurs at the same frequency in all races.

Sex
Bipolar I disorder affects men and women equally; bipolar II disorder is more common in women. Rapid-cycling bipolar disorder (4 or more episodes a year) is also more common in women than in men.

Clinical aspects
According to research done in 1999, ninety percent of people who have one manic episode have another within five years. Research published in the Journal of Clinical Psychiatry by SW Woods in 2000 concluded that ninety percent of people with bipolar disorder have at least one psychiatric hospitalisation.

Depressive symptoms are more frequent over the course of bipolar disorder than manic symptoms. According to research published in the Archive of General Psychiatry in 2003, people with bipolar I disorder experience depression three times more frequently than mania; patients with bipolar II disorder experience depression 37 times more frequently than manic symptoms. It is easy to see why bi-polar disorder can be misdiagnosed as depression as depression is the most common symptom.

Symptoms

Manic episodes are characterised by at least one week of profound mood disturbance, characterised by elation, irritability, or expansiveness. Three or more of the following symptoms must also be present to confirm diagnosis:

- Grandiosity (feeling of superiority and self importance)
- Decreased need for sleep
- More talkative than usual
- Racing thoughts or flight of ideas
- Easily distracted
- Increased level of goal-focused activity at home or at work
- Excessive pleasurable activities, often with painful consequences
  (eg) excessive spending of money, overuse of alcohol, sexual indiscretion

With major depressive episodes, the person experiences 5 or more of the following symptoms for at least two weeks, with at least one of them being either low or a loss of pleasure or interest:

- Depressed mood
- Markedly diminished pleasure or interest in nearly all activities
- Significant weight loss or gain or significant loss or increase in appetite
- Slow down in movements
- Agitation
- Loss of energy or fatigue
- Decreased ability to concentrate or marked indecisiveness
- The symptoms cause significant impairment and distress
- Preoccupation with death or suicide; person plans or attempts suicide

Physical Symptoms

Appearance
Depressed episode: You can experience lack of confidence and poor self esteem as a result of low mood. Clothes may be unkempt, unclean, un-ironed and ill-fitting. Clothes may be loose fitting as you may have lost weight. Your usual level of hygiene may diminish and may be observed as poor grooming, lack of shaving, and lack of washing and unkempt hair. Your movement may reduce and become slow. You may talk in low tones or in a depressed or monotone voice.

Manic episode: behaviour during the manic phase is often considered as the exact opposite of those in the depressed phase. You are hyperactive. You become restless, energised, and active. There is a tendency to talk and act fast. Your fashion sense can reflect your mood so can be bright and colourful and clothes might have been put on in haste so is disorganised.

Mood
Depressed episode: During the depressed episode you can feel sad, depressed, lost, vacant, and isolated. You can feel hopeless and helpless.

Manic episode: Your mood is inappropriately joyous, elated, and jubilant. You are euphoric. You can demonstrate annoyance and irritability, especially if the mania has been present for a significant length of time.

Thought content
Depressed episode: The depression gives the person a ñglass half emptyòmentality. Thoughts reflect your sadness. You become preoccupied with negative ideas.

Manic episode: This is the ñglass half fullòphase. During the manic phase, you may be excessively optimistic and self-confident. There is a very rapid production of ideas and thoughts. You can perceive your mind as being very active and see yourself as being highly engaging and creative.

Perceptions
Depression episode: Two forms of a major depression can occur. One has psychotic features and the other does not. With psychosis, you can experience delusions and hallucinations that are consistent with the mood. Delusions of having sinned may be accompanied by guilt and remorse giving the feeling of being utterly worthless. Paranoia can be a symptom.

Manic episode: About three quarters of people in the manic phase have delusions. Manic delusions reflect perceptions of power, prestige, position, self-worth, and glory.

Suicide/self-harm
Suicidal thoughts and self harm are more common in the depressive phase. They are rare in the manic phase.

Aggression
Aggression is more common in the manic phase. You may have no patience or tolerance for others. You can become highly demanding, violently assertive, and highly irritable.

Judgment/insight
Depressed episode: Depression clouds and dims judgment. You may fail to make important actions because they are so down and preoccupied with your plight. You may see no tomorrow; therefore, planning for it is difficult. Frequently, people in the middle of a deep depression forget to do important things like pay bills. Close family, friends and colleagues may have to persuade you to seek therapy as you may not be in a mental state to make the decision yourself.

Manic episode: The hallmark of this phase is seriously impaired judgment. You can end up making bad decisions in relation to work and family. You may make poor financial decisions. During the manic phase, you are less likely to listen to any feedback, suggestions, or advice from friends, family, or colleagues.

Other conditions with similar symptoms

Many psychiatric conditions may mimic, and at times coexist with bipolar disorder including schizophrenia, posttraumatic stress disorder, abuse of alcohol and cocaine or amphetamine use. In addition, symptoms associated with several medical conditions resemble manic episodes, including thyrotoxicosis (overproduction of thyroxine, a condition which can be treated by your doctor), partial complex seizures (form of epilepsy), systemic lupus erythematosus (autoimmune disease causing damage to organs), head injuries, HIV virus, syphilis (a sexually transmitted disease which can be cured with antibiotics), and steroid-induced mood symptoms (steroids are anti-inflammatory medication used for conditions like arthritis, bronchitis and asthma, they are safe when taken appropriately under doctor's supervision). Dementia should be considered a possibility in people with late onset bi-polar disorder (ie) people over 50.

Medication

Medication is not the only form of treatment. In addition to medical treatments, psychotherapy and sleep management are also parts of bipolar disorder treatment.

However, because the treatment of bipolar disorder is based primarily on medication to reduce the severity of symptoms, stabilise mood and prevent relapse, I will discuss it in some detail in this article. Treatment is normally started by a consultant psychiatrist.

For treatment of mania, lithium (Priadel®, Camcolit®), olanzapine (Zyprexa®), quetiapine (Seroquel®), risperidone (Risperdal®) and sodium valproate (Epilim®) may be used.

For prevention of mania, lithium and olanzapine may be used.

For the prevention of bipolar disorder unresponsive to lithium, carbamazepine (Tegretol®) may be used.

Other conditions these drugs may be used for
Olanzapine (Zyprexa®), quetiapine (Seroquel®) and risperidone (Risperdal®, Rispone®) are known as antipsychotics and can be used for other psychiatric conditions such as schizophrenia. Sodium valproate (Epilim®) and carbamazepine (Tegretol®) are also used for epilepsy.

General recommendations
The person suffering from bipolar disorder should be fully involved in decisions about their treatment and care. Some of the medication cannot be taken during pregnancy due to the risk to the unborn child. Contraception and the risks of pregnancy (damage to the unborn child and the risk of relapse associated with stopping or changing medication) should be discussed with all women of child-bearing potential, regardless of whether or not they are planning a pregnancy.

When experiencing mania, or severe depressive symptoms, you should normally be seen again by the doctor within a week of first assessment, and then regularly at appropriate intervals, for example, every 2ï 4 weeks in the first 3 months and less often after that, if response is good.

Management of the manic phase

Only lithium, olanzapine, quetiapine, risperidone and valproate are licensed for the treatment of acute mania in the Ireland. If you are not taking an antidepressant at the onset of an acute manic episode, the antidepressant should be stopped. This is because the antidepressant can exacerbate the manic symptoms. This may be done abruptly or gradually, depending on how severe your manic symptoms are and your previous experience of withdrawal symptoms from anti-depressants.

Drug treatment for mania for people <u>not</u> taking anti-manic medication

If you develop mania when not taking anti-manic medication, treatment options include starting an antipsychotic (olanzapine, quetiapine, and risperidone), valproate or lithium. When making the choice, doctors should consider:

Åprescribing an antipsychotic if there are severe manic symptoms
Åprescribing valproate or lithium if these have worked before
Åavoiding valproate in women of child-bearing potential
Åusing lithium only if symptoms are not severe because it has a slower onset of action than antipsychotics and valproate.

Initially, if the person is severely agitated, short-term use of an anti-anxiety drug, such as lorazepam (Ativan®), may be considered in addition to the anti-manic agent.

If treating acute mania with antipsychotics (olanzapine, quetiapine or risperidone), the following should be taken into account:

ÅIndividual risk factors for side effects. For example, antipsychotics can increase the risk of diabetes and cause weight gain.
ÅStart at the lowest possible dose and increase slowly according to response
ÅIf an antipsychotic proves ineffective, adding valproate or lithium should be considered
ÅOlder people are at greater risk of sudden onset of depressive symptoms after recovery from a manic episode.

Carbamazepine should not be routinely used for treating acute mania. It should only be used if the person cannot tolerate lithium.

Drug treatment of acute mania for people <u>already</u> taking anti-manic medication

If currently taking anti-psychotic:
If a patient already taking an antipsychotic experiences a manic episode, the dose should be checked and increased if necessary. If there are no signs of improvement, the addition of lithium or valproate should be considered

If currently taking lithium:
If a person already taking lithium experiences a manic episode, blood levels of lithium levels should be checked. If levels are insufficient, the dose should normally be increased to a maximum blood level of 1.0 mmol per litre. If the response is not adequate, adding an antipsychotic to lithium should be considered.

If currently taking valproate:
If a patient already taking valproate experiences a manic episode, the dose should be increased until the symptoms start to improve or side effects limit further dose increase. If there are no signs of improvement, the addition of olanzapine, quetiapine, or risperidone should be considered.

If currently taking carbamazepine:
For patients who present with mania when already taking carbamazepine, the dose should not routinely be increased. Adding an antipsychotic should be considered, depending on the severity of mania and the current dose of carbamazepine. Interactions with other drugs are common with carbamazepine so must be considered.

The management episodes of depression

Managing depressive symptoms in bipolar disorder has some similarities to managing depression in people who do not have bi-polar disorder (uni-polar depression). However, in bipolar disorder, antidepressants carry the risk of bringing on manic states. Long term treatment with antidepressants is not recommended in bipolar depression; preventive medication such as lithium or olanzapine has a greater role. When prescribed an antidepressant, an anti-manic should also be used.

Treatment of depressive symptoms

Patients not taking anti-manic medication

A person who is prescribed antidepressant medication should also be prescribed an anti-manic drug. Antidepressant treatment should begin at a low dose and be increased gradually if necessary.

Patients taking anti-manic medication

If a person has a severe depressive episode when taking anti-manic medication, prescribers should first check the dose of the anti-manic drug is sufficient and increase if necessary.

For patients with moderate or severe depression, prescribers should normally consider prescribing an SSRI** antidepressant (but not paroxetine in pregnant women). Quetiapine should be added if the patient is already taking anti-manic medication that is not an antipsychotic. (eg) lithium, valproate.

**SSRI- this is a serotonin selective reuptake inhibitor which is the newest type of antidepressant. SSRIs are the most commonly prescribed antidepressants as they have the fewest side effects and are generally very effective. Examples include fluoxetine (Prozac®), citalopram (Cipramil®), escitalopram (Lexapro®) and paroxetine (Seroxat®). In Whelehans, we also stock generic versions of these drugs which are equally effective but a lot less expensive. Ask our pharmacist for more information.

When to avoid antidepressants and risk prevention

Antidepressants should be avoided for patients with depressive symptoms who have rapid-cycling bipolar disorder (4 or more episodes per year) or a recent manic episode. Instead the doctor will consider increasing the dose of the anti-manic agent or the addition of a second anti-manic agent (including lamotrigine).

When antidepressant treatment is started, you need to be aware of:

- the possibility of manic symptoms
- the fact it takes up to two weeks for mood to improve
- the need to take medication as prescribed and the risk of discontinuation/withdrawal symptoms
- a small risk of restlessness, suicidal thoughts, increased anxiety and agitation when the antidepressant is started (usually very short term)
- the need to seek help promptly if side effects are distressing.

Stopping antidepressants after an acute depressive episode

When symptoms of depression have been significantly less severe for 8 weeks, stopping the antidepressant medication should be considered, to minimise the risks of switching to mania.

The dose of antidepressant should be gradually reduced over several weeks, while maintaining the anti-manic medication. Particular care is needed with paroxetine (Seroxat®) and venlafaxine (Efexor XL®) because they have a higher risk of withdrawal side effects.

Options if depression does not respond to antidepressant If depressive symptoms do not fully respond to an antidepressant, options include:

- increasing the dose of the antidepressant
- switching to an alternative antidepressant (eg) mirtazapine (Zispin®) or venlafaxine (Efexor XL®)
- adding quetiapine or olanzapine if the patient is not already taking one of these, or
- adding lithium if the patient is not already taking it.

If a patientôs depressive symptoms have failed to respond to at least three courses of treatment for depression, the person should be referred to a specialist in bipolar disorder.

The management of rapid-cycling bipolar disorder

A patient who has four or more acute episodes in a year is defined as having rapid-cycling bipolar disorder. A key aspect of treatment should be to avoid medication which causes the person to switch from one pole to another. Antidepressants should be avoided. For the treatment of rapid-cycling bipolar disorder, it is important to focus on long-term treatment rather than on treating individual episodes and symptoms.

The use of ECT in severe manic and depressive episodes

Electroconvulsive therapy (ECT) is recommended only to achieve rapid and short-term improvement of severe symptoms after other treatment options has proven ineffective and/or when the condition is considered to be potentially life-threatening. It involves the application of an electric pulse to the personôs head hence stimulating brain activity. It is done under strict supervision in hospital.

A healthy lifestyle and preventing re-occurrence

People with bipolar disorder need to be aware of the importance of proper sleep and a regular lifestyle. Shift work, night flying and flying across time zones, and routinely working excessively long hours can increase the risk of relapse.

Additional support after significant life events, such as loss of job or a close bereavement is important. This should include increased monitoring of mood and general well-being by family, friends and health professionals, and encouraging the person to discuss difficulties with family and friends.

Counselling from a psychiatrist can be of great benefit and can include the following:

- education about the illness, and the importance of regular daily routine and sleep and concordance with medication
- monitoring of mood, detection of early warnings and strategies to prevent progression into full-blown episodes
- enhance general coping strategies.