Bipolar

Bipolar disorders

Clinical presentation

It can be particularly challenging to treat people with bipolar disorder due to the broad range of emotions experienced, which can impact on the relationship between the client and the therapist [540]. Depending on which phase of the disorder a client is in, they may present with either symptoms of depression or mania/hypomania. If the person is in between episodes, they appear to be completely well. People with bipolar disorder predominantly present to services during the depressive phases of the disorder rather than during the periods of elation.

If experiencing a depressive episode, the client may present with low mood; markedly diminished interest or pleasure in all, or most activities; sleep disturbances; appetite disturbances; irritability; fatigue; psychomotor agitation or retardation; poor concentration; feelings of guilt, hopelessness, helplessness and worthlessness; and suicidal thoughts. When experiencing mania/hypomania however, a client's mood is persistently elevated, and symptoms of grandiosity, flights of ideas, hyperactivity, decreased sleep, psychomotor agitation, talkativeness and distractibility may be present. Mania and hypomania may lead to a loss of insight, which can place the person at risk, and impact negatively on medication compliance.

Managing symptoms of bipolar

In general, if the client presents during a depressive episode, management of symptoms should follow the guidelines for the management of depressive symptoms (see Table 34). As previously mentioned, negative mood is often a trigger for relapse to AOD use and addressing depressive symptoms is an important component of relapse prevention [557]. If, however, the client is experiencing a manic episode or symptoms of psychosis, consultation with a medical practitioner is recommended for the prescription of appropriate pharmacological interventions.

The techniques outlines in Table 35 may assist in the management of a person experiencing symptoms of mania or hypomania. If the client is experiencing a manic episode or symptoms of psychosis, consultation with a medical practitioner is recommended for the prescription of appropriate pharmacological interventions. Some clients may be aware that they are unwell and will voluntarily seek help; others may lack insight into their symptoms and refuse help. In some instances a person's manic symptoms can put both the client and others at risk of harm. In such circumstances mental health services should be contacted, whether the client wants such a referral to be made or not.

Table 34: Dos and don'ts of managing a client with depressive symptoms of bipolar

Do:

- ✓ Encourage and emphasise successes and positive steps (even just coming in for treatment).
- ✓ Take everything they say seriously.
- ✓ Maintain eye contact and sit in a relaxed position – positive body language will help you and the client feel more comfortable.
- ✓ Use open-ended questions such as 'So tell me about...?' which require more than a 'yes' or 'no' answer. This is often a good way to start a conversation.
- ✓ Constantly monitor suicidal thoughts and talk about these thoughts openly and calmly.
- ✓ Encourage the client to express his/her feelings.
- ✓ Be available, supportive and empathetic.
- ✓ Offer realistic hope (i.e., that treatment is available and effective).
- ✓ Encourage regular sleep, exercise and eating patterns.
- ✓ Keep language clear, specific and simple.
- ✓ Assist the client to identify warning signs that they may become unwell.
- ✓ Provide contact details of counselling services and offer to make referrals if required (many depressed people struggle to do this alone).
- ✓ Encourage participation in healthy, pleasurable and achievement-based activities (e.g., exercise, hobbies, work).

Don't:

- × Make unrealistic statements or give unrealistic hope, like 'everything will be fine'.
- × Invalidate the client's feelings.
- × Be harsh, angry, or judgemental. Remain calm and patient.
- × Lose hope or become frustrated.
- × Act shocked by what the client may reveal.

Adapted from Scott et al. [558], Clancy and Terry [296] and Headspace [559].

Table 35: Dos and don'ts of managing a client experiencing mania/hypomania

Do:

- ✓ Ensure the safety of the client, yourself, and others.
- ✓ Assist the client identify warning signs that they may become unwell.
- ✓ Help to reduce triggers that aggravate the person's symptoms (e.g., reduce stimulation such as noise, clutter, caffeine, social gatherings).
- ✓ Speak clearly and calmly, asking only one question or giving only one direction at a time.
- ✓ Answer questions briefly, quietly, calmly and honestly.
- ✓ Use a consistently even tone of voice, even if the person becomes aggressive.
- ✓ Encourage regular sleep, exercise and eating patterns.
- ✓ Be cautious about becoming swept up by the person's elevated mood.
- ✓ Point out the consequences of the client's behaviour. Be specific.
- ✓ If the person is well enough, discuss precautions they can take to prevent risky activities and negative consequences (e.g., give their credit cards and/or car keys temporarily to a trusted family member or friend to prevent reckless spending and driving).
- ✓ If promiscuity or socially inappropriate behaviour is a problem encourage the person to avoid situations in which his/her behaviour may led to negative consequences.
- ✓ Encourage the person to postpone acting on a risky idea until their mood is stable.

Table 35: Dos and don'ts of managing a client experiencing mania/hypomania

- ✓ Ensure both you and the client can access exits – if there is only one exit, ensure that you are closest to the exit.
- ✓ Have emergency alarms/mobile phones, and have crisis teams/police on speed dial.
- ✓ If the person is placing him/herself at risk, or they are experiencing severe symptoms of psychosis, arrange transfer to an emergency department for assessment and treatment by calling an ambulance on 000.

Don't:

- × Argue, criticise or behave in a threatening way towards them. Consider postponing or avoiding discussion of issues that aggravate the client for the time being. Try to talk about more neutral topics.
- × Get visibly upset or angry with the client. Remain calm and patient.
- × Confuse and increase the client's level of stress by having too many workers attempting to communicate with him/her.
- × Get drawn into long conversations or arguments with the person as these can be overstimulating and upsetting. People with elevated moods are vulnerable despite their apparent confidence, and they tend to take offence easily.
- × Leave dangerous items around that could be used as a weapon or thrown.
- × Laugh (or let others laugh) at the person.
- × Act horrified, worried or panic.

Treating bipolar disorders

There are several treatment options available for the treatment of bipolar disorders, including psychotherapy, pharmacotherapy, electroconvulsive therapy (ECT), e-health interventions, as well as complementary and alternative therapies (e.g., dietary supplements). The evidence base surrounding each of these treatments is discussed below.

Psychotherapy

Although research on psychological treatments for comorbid bipolar disorder and AOD use is scarce, one group of researchers have developed an integrated, 20-session, psychosocial group treatment program for this comorbidity, which has shown some positive findings in relation to AOD use [560, 561]. The program employs a cognitive behavioural relapse prevention model that integrates treatment by focusing on similarities between recovery and relapse processes in bipolar disorder and AOD use disorder. More recently, a briefer version of integrated group therapy (12 sessions) has been shown to be effective in terms of its positive impact on mood and substance use [562]. When delivered by AOD workers with little or no training in CBT, or prior experience with the treatment of bipolar disorder, this brief version of integrated group therapy had superior outcomes relative to standard group drug counselling. Although psychological treatments appear to have positive outcomes among people with comorbid bipolar disorder, it is not well understood how the improvements work – i.e., whether it is the psychological therapy addressing the AOD use, the bipolar symptoms, or both together, that are associated with positive outcomes [563].

Pharmacotherapy

For comorbid bipolar and AOD use disorders, multiple medications are often used to treat each specific disorder, such as the use of mood stabilisers (see Table 36), antipsychotics (see Table 33), and/or antidepressants (see Table 38) for the bipolar disorder, in conjunction with medication specifically to treat the AOD use disorder (e.g., naltrexone for alcohol use disorder) [540]. A recent update on the treatment of bipolar disorders recommended initiating pharmacological treatment with mood stabilisers and/or

Table 36: Mood stabiliser medications

Drug name	Brand names
Lithium	Lithicarb, Quinolum SR
Sodium valproate	Epilim, Valpro
Carbamazepine	Tegretol, Teril
Olanzapine	Zyprexa
Quetiapine	Seroquel
Risperidone	Risperdal, Risperdal Consta
Aripiprazole	Abilify
Solian	Amisulpride
Lamotrigine	Lamictal
Topiramate	Topamax

Adapted from Black Dog Institute [565]. For a full list of generic brands available, see the Therapeutic Goods Administration website (https://www.tga.gov.au/).

antipsychotics, and then later supplementing the treatment with antidepressant medication, due to the possibility of antidepressant-induced mania [564].

The effectiveness of mood stabilisers (e.g., lithium, sodium valproate, lamotrigine) in treating comorbid bipolar disorder and AOD use is yet to be fully established with only a small number of controlled trials in this area. An RCT examining the effectiveness of lithium in treating adolescents with bipolar disorder and AOD use disorders (primarily alcohol and/or cannabis) found that, relative to placebo, lithium had a positive effect on bipolar symptoms and on AOD use [566]. A further study demonstrated that lithium had an impact on reducing cannabis and cocaine use in people with comorbid bipolar disorder, but it is difficult to generalise the findings of this study due to less than one-quarter of the original sample completing the stabilisation phase and continuing into the main portion of the study [567].

Promising findings have also been found relating to the use of sodium valproate (or divalproex). In an uncontrolled study, Salloum and colleagues [568] found beneficial effects from divalproex alone in reducing bipolar symptoms and cocaine use. There is also some evidence to suggest that the addition of sodium valproate may further improve the effects of lithium [540]. In an RCT of people with bipolar disorder and alcohol use disorders, Salloum and colleagues [569] found that those randomised to receive lithium plus valproate had a greater reduction in heavy drinking days relative to those randomised to receive lithium alone. Manic and depressive symptoms improved equally in both groups. However, Kemp and colleagues [567] found no additional benefits for mood and AOD use when using divalproex and lithium, compared with lithium alone. As mentioned previously however, the findings of this study need to be interpreted with caution given the high drop-out rate.

Lamotrigine has been found to be associated with improvements in bipolar symptoms, craving, and AOD use in a number of open-label, uncontrolled trials [570, 571]. However, in a more recent RCT, the effects of lamotrigine on mood and cocaine use were not significantly different to placebo, although money spent on cocaine was reduced in the lamotrigine group [572].

A small number of uncontrolled, open-label trials have examined the use of the anti-psychotic quetiapine in the treatment of bipolar disorder comorbid with AOD use disorders. These studies have found that quetiapine has a positive impact on psychiatric symptoms, but no impact on AOD use [573, 574]. Furthermore, a large RCT examining the efficacy of quetiapine as an adjunct to lithium or divalproex among individuals with bipolar disorder and alcohol dependence found that there was no additional improvement in symptoms of mania or heavy drinking days, relative to a placebo control [575]. Lastly, it should be noted that the potential for the misuse of quetiapine, particularly in prison settings, has been well documented [576].

It is also important to bear in mind that clients with a comorbid bipolar disorder may be less likely to comply with medication if they enjoy their manic episodes. Measures to increase medication compliance may be particularly pertinent among this group (discussed later in this chapter). Other strategies to promote medication compliance among clients with comorbid bipolar disorder include the *Improving Treatment Adherence Program*, which is an adjunctive psychosocial approach designed to improve treatment adherence [577]. The *Improving Treatment Adherence Program* is delivered through individual sessions, a meeting with the client's family member and/or significant other, and follow-up telephone contacts with the client and his/her significant other. Whilst an RCT testing this program is yet to establish the program's efficacy, early results indicate that the intervention appears promising both in terms of feasibility and acceptability to clients, and also in terms of enhancing the benefits of existing treatments.

Electroconvulsive therapy (ECT)

ECT is suggested as a second-line treatment option for bipolar disorder in very severe cases (e.g., in cases of severe depression and suicidality), and in pregnant woman with severe symptoms [578]. However no research studies to date have currently assessed the efficacy of ECT in treating co-occurring bipolar and AOD use disorders.

E-health interventions

There are several online interventions to support the mental health of people with bipolar disorders, including *MoodSwings* [579], *Living With Bipolar* [580], *Beating Bipolar* [581], the *Bipolar Education Programme* [582], and *HealthSteps for Bipolar Disorder* [583]. Most of these interventions are in the early stages of evaluation. Feasibility and preliminary studies of *Living With Bipolar* [580] and *Bipolar Education Programme* [582] are promising. No online interventions have yet been developed for treating comorbid bipolar and AOD use disorders specifically.

Physical activity

A small number of studies with relatively small samples have examined the effect of exercise on bipolar disorders. Ng and colleagues [584] conducted a small, retrospective chart review, and found that depression and anxiety improved among bipolar inpatients who participated in a voluntary 40-minute, supervised group walking activity, every weekday morning, compared to non-walkers. However, there was no clinical difference in overall improvement between walkers and non-walkers [584]. A small open trial examining the short term effects of aerobic training on depression and bipolar disorder found that aerobic training slightly improved symptom severity for those with bipolar disorder [585]. Another small RCT examined the effect of a short-term, maximum endurance exercise program as an accompanying treatment to pharmacotherapy, and found that, relative to control (gentle stretching and relaxation), depression scores were significantly reduced among the exercise group [586].

Although the aforementioned studies provide evidence to suggest that regular physical activity can assist in the reduction of depressive symptoms, there is preliminary research pointing to the existence of possible exacerbation of mania among some people [587, 588]. Although exercise may be beneficial in redirecting

excess energy for some, others found their manic symptoms were aggravated, potentially risking a cycle of manic and hypomanic symptoms [589]. It has been suggested that the exacerbation of manic symptoms may be due to direct effects on mood, or indirectly on excessive goal-focused activities, which can be a risk pathway for bipolar disorder [590, 591]. However, these preliminary findings originate from a small qualitative study and require further empirical evidence, with some participants in the study finding exercise calming [587]. No research has been conducted to examine the efficacy of exercise among people with comorbid bipolar and AOD use; however, given the unknown and potentially risky relationship with mania, physical activity among people with comorbid disorders should be closely monitored.

Complementary and alternative therapies

Dietary supplements

There have been few reviews that have examined the evidence for the safety and efficacy of dietary supplements for bipolar disorders. Although research has found some benefit with regards to both depressive symptoms (e.g., omega-3 supplementation [592, 593]), and mania symptoms (e.g., magnesium supplementation [594-596]), many therapies have the potential to induce mania or interact with pharmacotherapies (e.g., St John's Wort [597-599]); the extent to which needs further in-depth examination.

Summary

Several psychological and pharmacological approaches for the treatment of co-occurring bipolar disorder and AOD use appear promising, however further research is required to establish which therapeutic approaches are particularly effective for this comorbidity. Box 15 illustrates the continuation of case study C, following Layla after the identification of her bipolar disorder.

Box 15: Case study C: Treating comorbid bipolar and AOD use: Layla's story continued

Case study C: Treating comorbid bipolar and AOD use: Layla's story continued

Layla completed her assessment with the AOD worker, commenting that it was one of the only times she had really felt listened to without being judged. The AOD worker emphasised that should Layla wish to work on her AOD use, they would work together with her psychiatrist and any other service that may be of assistance, to help her manage her bipolar disorder. Although sceptical, Layla accepted this offer and began embarking on a plan that involved a concurrent approach to her mental health and AOD use, with very active communication between her health providers. This communication was facilitated by regular meetings involving Layla and the professionals involved in both her mental health care and AOD treatment. In addition, Layla's medications were comprehensively reviewed, and, rather than a process of 'tweaking' and modifying medications, a conference was convened to consider the best medication approach. This conference was attended by Layla, who was for the first time able to freely express her reservations about some of the medications that she was taking; in particular, how a particular mood stabilising drug made her feel overwhelmingly flat.

In addition to the use of psychotherapy and medication, the team identified the need to deal more generally with Layla's lifestyle, and with initial encouragement and support she was able to begin to attend regular training sessions at the gym and, thus, begin the process of losing some of the weight she had gained over the years. She was also able to contact some of her friends she used to swim with, and, with the encouragement of her care coordinator, resumed her interest in music.

Box 15: Case study C: Treating comorbid bipolar and AOD use: Layla's story continued

Key points:

- In cases of bipolar disorder comorbid with AOD use, treatments need to be coordinated and carefully integrated.
- Although there are many effective medications to address disturbances in mood, as with all medications, mood stabilisers can have significant side effects. In particular, mood stabilisers have the potential to make a client feel flat.
- Strategies to address medication compliance, particularly over the long-term, are a pertinent aspect of treatment.
- Without addressing the familial and social consequences of longstanding bipolar disorder, the client's quality of life will remain much diminished. As such, integrating the rehabilitative aspects of treatment may have long-term benefits. Physical activity and exercise have physical and psychological benefits, and may also help address some of the side effects of medications used to treat bipolar disorder.