

AUDIT OF THE PREVALENCE OF ANXIETY IN BIPOLAR DISORDER – A COMORBIDITY THAT REQUIRES ATTENTION AND ACTION

Jina Pakpoor^{5,6}, Sophie Butler⁴, Mark Agius^{1,2,3} & Rashid Zaman^{1,2}

¹South Essex Partnership University Foundation Trust, UK

²Department of Psychiatry University of Cambridge, Cambridge, UK

³Clare College Cambridge, Cambridge, UK

⁴Melbourne Health, Melbourne, Australia

⁵Selwyn College Cambridge, Cambridge, UK

⁶School of Clinical Medicine University of Cambridge, Cambridge, UK

SUMMARY

Bipolar affective disorder (BPD) frequently occurs with co-morbid mental health problems. This study shows that the prevalence of co-morbid 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 co-morbid 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.

Key words: bipolar affective disorder - co-morbidity - anxiety

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INTRODUCTION

Psychiatric co-morbidity is a well recognised phenomenon (Kessler 1994, Goodwin 2002, Cosoff 1998); Studies have shown prevalence of anxiety disorders as a comorbidity to bipolar disorder (BPD) to be as high as 30% for obsessive-compulsive disorder and 15% for panic disorder (Boylan 2004). A study following a thousand out-patients with BPD prospectively for a year found that a comorbid anxiety disorder was present in 31.9% of participants. Other studies have shown this rate to be as high 55.8% (Otto 2006). The presence of an anxiety disorder has been shown to lead to significantly worse outcome on global as well as specific illness measures (Otto 2006). Importantly, this comorbidity was associated with more unwell days, a reduced likelihood of timely recovery from depression, risk of relapsing earlier, a lower quality of life and reduced role function over the year. This effect was even greater for those suffering from more than one comorbid anxiety disorder, although type of disorder is also very important with generalized anxiety disorder and social phobia having been shown to have the most negative impact on outcome (Otto 2006). This highlights the importance of targeting this issue; not only does anxiety disorder have its own negative effects on the individual, but it predicts a poor bipolar course (Henry 2003). Other studies have consistently shown similar increased rates of anxiety disorders as a comorbidity of BPD (Dilsaver 2003, Dilsaver 2003, Feske 2000).

Although co-morbid anxiety with BPD is highly prevalent and the clinical sub-population most at risk is

recognised, these anxiety symptoms are under-reported and, more importantly, under-treated. This is especially concerning given the negative impact that this will have on the individual. This study examines the prevalence of co-morbid anxiety in patients diagnosed with BPD and discusses the implications of such co-morbidity.

METHOD

We carried out an audit of patients with Bipolar Disorder at Weller Wing Outpatients, Bedford Hospital. Previously it had been established by the treating doctor that anxiety should be assessed routinely and formally using GAD-7 rating scale.

In a sample of 190 bipolar disorder patients registered as outpatients at the Weller Wing, Bedford hospital, United Kingdom, the prevalence of anxiety as judged by GAD-7 scores was examined.

RESULTS

Only 77 of 190 bipolar out-patients at the Weller Wing had a GAD-7 form included in their patient records. 73 out of these 77 (94.8%) patients met the criteria for anxiety (a minimum score of 5). 44 of the 77 (57.1%) patients met the criteria for severe anxiety (a minimum score of 15).

DISCUSSION

This study has shown a high prevalence of anxiety, and in particular severe anxiety, as a comorbidity of

BPD in the patients examined. Additionally, the results demonstrate that this is currently an issue that is going unnoticed as the majority of patients had not been assessed for anxiety at all. Having co-morbid 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, a higher number of mood episodes and with rapid mood switching (Lee 2008). It is also associated with a longer time to remission of BPD and more severe psychopathology. Generally a person with both BPD and anxiety will have lower functioning as scored on Global Assessment of Functioning Scale (GAF) and diminished role functioning. On several measures, bipolar patients with comorbid anxiety disorders were more significantly ill than bipolar patients without comorbid anxiety disorders (Cassano 1999, Kilbane 2009).

It is particularly important that the risk of suicidality is recognised in this group of patients; studies have shown that there are higher levels of suicidal ideation in this population and there is a "dose-response" relationship between the co-morbid anxiety symptoms and suicide attempts (Simon 2004, Toniolo 2009). There is also specific need for improved clinical monitoring. The treatment of bipolar disorder and anxiety 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. There is some evidence that co-morbid anxiety reduces the response of BPD symptoms to antiepileptic therapies (Dilsaver 2003). Treatment is further complicated by the fact that additional co-morbidities are often found in those already with a co-morbid anxiety disorder e.g. substance abuse, alcohol abuse and eating disorders (McElroy 2001, Pini 1999, Simon 2004).

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 (Himmelhoch 1998, Valença 2005). Third, that adolescents with anxiety are more likely to develop BPD and those with BPD are more likely to develop anxiety (Johnson 2000).

Familial studies have also supported this relationship. There is an inherited risk of BPD and anxiety symptoms which could reveal a shared genetic aetiology (Dilsaver 2006, MacKinnon 2002). There is also a low prevalence of panic attacks (anxiety symptoms) in families with no affective disorders (Doughty 2004). 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 (MacKinnon 1998). 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 (Rotondo 2002).

BPD and anxiety disorders could be seen as symptoms on the same affective continuum (Jones 2013). For example, those with social phobia could be a subset of bipolar patients who sit on the scale of inhibitory restraint vs. disinhibited mania (Himmelhoch 1998) or those with panic disorder a subset of patients whom exhibit symptoms that could be described as dysphoric manic/mixed hypomanic states (Perugi 2001).

Treatment

Comorbidity specific pharmacotherapy for anxiety disorders in BPD has been found to be limited (Cazard 2013, El-Mallakh 2008). The difficulties of choosing effective treatment options for BPD when an anxiety disorder is also present are compounded by that fact that effective medications for anxiety (e.g. antidepressants) often have a negative effect on BPD symptoms (Freeman 2002, Yatham 2009). 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) (NICE 2004). Specific antipsychotics that have some evidence for benefit in BPD are quetiapine, aripiprazole, risperidone and ziprasidone (Hollon 2010).

There is a wealth of evidence for psychological interventions successfully alleviating anxiety symptoms and there is evidence that psychological therapy can be a useful adjunct to medications for bipolar treatment. These management strategies reduce the need for pharmacological input and there is an association between improved awareness of symptoms and better insight for this population (those who have both BPD and anxiety), suggesting that they would be good targets for psychological interventions. 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; further research in this area is warranted and feasible (Perich 2013, Jones 2013)

CONCLUSION

The combination of co-morbid 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. Hence, as a result of our audit, we recommend that all patients who are assessed for bipolar disorder should have a formal assessment for anxiety using a structured instrument such as GAD-7.

There is limited evidence on how best to manage these conditions together. Pharmacological approaches are strongly limited by the risk of mood switching under antidepressants and drug dependence on anxiolytics such as benzodiazepines. Options include choosing a mood stabiliser with anxiolytic effects, using an anxiolytic antipsychotic with a mood-stabilising effect and avoiding SSRIs when possible. Psychosocial interventions such as cognitive-behavioral therapies or psychoeducation appear essential to improve in a correct way the global functioning and quality of life of these patients. 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.

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Correspondence:

Mark Agius, MD
SEPT at Weller Wing, Bedford Hospital
Bedford, Bedfordshire, MK42 9DJ, UK
E-mail: ma393@cam.ac.uk