TREATMENT OF RAPID-CYCLING BIPOLAR DISORDER

PAMELA MARCUS, RN,APRN/PMH/BC
14460 Old Mill Rd. #201
Upper Marlboro, Maryland 20772
marcusRN@verizon.net

CONFLICT OF INTEREST

- Ms. Marcus has no conflicts of interest.
- There are no discussions of off-label medications in this presentation

OBJECTIVES

- Differentiate between symptoms manifested by individuals with Bipolar I, Bipolar II, and Mixed Bipolar disorder, as compared to Rapid-Cycling Bipolar Disorder with case study
- Describe the medications most often used for patients with Bipolar Disorder

OBJECTIVES

- Identify two nursing interventions that are most helpful when providing psycho-education for patients and their families to better understand and manage symptoms of Rapid Cycling Bipolar Disorder. Discussed using case study

BIPOLAR DISORDER, OVERVIEW

- Affects approximately 1% (2-2.5 million) in the USA, ages 18 and older
- First manic episode- 18-20 years old
- Earlier age of onset – worse outcomes, including rapid cycling in adulthood
- Individuals with Bipolar Disorder account for one quarter of all suicidal deaths reported in the general population.

BIPOLAR DISORDER

- Bipolar I affects men and women equally
- Bipolar II more common in women
- Women are more likely to have mixed mania and manic switches during treatment with an antidepressant
- Rapid cycling: four or more episodes per year
- Frequent cycling: two to three episodes a year

BIPOLAR I

- One or more manic episode alternating with a major depressive episode
- Manic episode – Persistent elevated, expansive or irritable mood
- Sleep disturbances
- Increase distracted, restless
- Impulsive behavior
- Exaggerated self-esteem

BIPOLAR I

- Manic episodes begin suddenly – lasting a few days to a few months
- Abrupt mood shifts – rapid changes from euphoria to anger or depression
- Individuals with depressive symptoms tend to be less responsive to conventional therapy

BIPOLAR II

- Major depressive episode and one hypomanic episode
- No history of a manic or mixed episode
- No psychotic features
- Hypomanic episodes usually occur before or after a major depressive episode
- Diagnosis is difficult

RAPID CYCLING

- Four or more manic episodes for at least 2 weeks in a year
- Have partial or full remission for 2 months or switch to the opposite mood (if manic; switches to depressed mood)
- High risk of recurrence and resistance to treatment
- Greater severity of symptoms of mania and depression

Theories of Etiology

ETIOLOGY:GENETIC

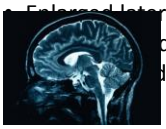
- Bipolar disorders – highly inheritable
- Complex mode of inheritance, involving multiple interacting genes
- Dysregulation in gene G protein receptor GRK3) – dopamine metabolism

ETIOLOGY:GENETIC

- Genetic: Concordance rates in monozygotic twins 67% ; Dizygotic twins 19%.
- Research is being done on genetic testing for bipolar disorder; including where the genetic disruption may be occurring
- Genetic association of serotonin system genes is being conducted

NEUROANATOMIC ISSUES

- Volume reduction in subregion of prefrontal cortex
- Amygdala and striatal enlargement
- Midline cerebellar atrophy
- Enlarged lateral and third ventricle with white density in 10-30% of individuals disorder



NEUROTRANSMITTERS

- Increase in sensitivity of postsynaptic receptors
- Dysregulation in dopamine and serotonin along with deficits in other systems, such as GABA
- Signaling pathway abnormalities and altered neurotransmitters; G proteins translate the signals and relay the signals to the second-messenger systems are increased with bipolar disorder

PSYCHOLOGICAL INFLUENCES

- Response to biological makeup and coping skills
- Faulty beliefs about self and the world around them
- Risks do not have consequences
- Goal striving – euphoria – drive increases regardless of feedback from others and disruption in daily routine

PSYCHOLOGICAL INFLUENCES

- Psychosocial stressors trigger bipolar episodes by disruption of usual social rhythms
- Disruption of circadian systems

MEDICATION MANAGEMENT

CHOOSE THE BEST MEDICATION

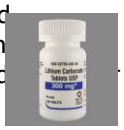
- Syndrome targeting (the pattern and stage of the illness)
- Symptom targeting
- Awareness of interactions
- Best drug class
- Mechanisms of drug action

CHOOSE THE BEST MEDICATION

- Symptoms presented
- History and patterns of illness
- Side effect profile
- Personal and family responses to treatment
- Cost
- Ease of administration
- Onset of action
- Drug to drug interaction

USE OF LITHIUM

- LiCo3 is an older mood stabilizer, continues to demonstrate good therapeutic results and is seen first line treatment for a mood



MOOD STABILIZER

- Treatment of choice in **manic phase**
- LiCo3 and Valproate are the two first line treatment choices
- Second line alternative is Carbamazepne or LiCo3 and valproate

MOOD STABILIZERS

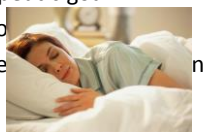
- **Rapid cycling:**
- Valproate; first line
- Carbamazepine; first line
- Second line alternative:
  - LiCo3 and valproate
  - LiCo3
  - LiCo3 and carbamazepine

MOOD STABILIZERS

- **Mixed episode or dysphoric mood**:
- Valproate; first line
- LiCo3 or Carbamazepine
- Gabapentin
- Lamotrigine
- Topiramate
- Second line alternative:
- LiCo3 and valproate

ADJUNTIVE MEDICATIONS

- **Manic with psychosis**:
- Therapeutic goal:
- Contro
- Induce n



ADJUNTIVE MEDICATIONS

- First line: and a high or medium potency antipsychotic to the mood stabilizer
- Benzodiazepine may be added to the antipsychotic and mood stabilizer
- Low potency antipsychotic

ADJUNCTIVE MEDICATIONS

- **Severe mania without psychosis**
- Add a benzodiazepine to the mood stabilizer
- Add a high or medium potency antipsychotic to the mood stabilizer and benzodiazepine.

ADJUNTIVE MEDICATIONS

- **Hypomanic:**
- Add a benzodiazepine to the mood stabilizer
- Add a high or medium potency antipsychotic
  - This is rarely needed, but is sometimes helpful.

TREATING THE ACUTE PHASE

- **Major depression with psychotic features:**
- ECT
- Mood stabilizer and antidepressant with an antipsychotic

TREATING THE ACUTE PHASE

- **Severe major depression, no psychosis**:
- Mood stabilizer and antidepressant
- Do not use antidepressants as an monotherapy to prevent mania/hypomanic episodes
- Phototherapy when depression occurs in late fall or winter

TREATING THE ACUTE PHASE

- **Milder major depressive episode:**
- Mood stabilizer and an antidepressant
- Mood stabilizer alone

ADJUNCTIVE MEDICATIONS

- **Insomnia:**
- Add benzodiazepine
- Second line
  - Add trazodone
  - May use a sedating antidepressant

ADJUNCTIVE MEDICATIONS

- **Psychotic symptoms in the depression:**
- Add a high or medium potency conventional antipsychotic in addition to the mood stabilizer and antidepressant regimen

IMPORTANT ITEMS TO NOTE

- When starting a patient on an antidepressant for severe depressive episode; note mood changes to determine if the mood has switched into a mania or hypomania
- If the patient demonstrates manic or hypomanic symptoms, discontinue the antidepressant

IMPORTANT ITEMS TO NOTE

- Check thyriod function studies
- Individuals with rapid cycling bipolar disorder frequently have hypothalamic-pituitary-thyroid axis abnormalities
- Cytomel 25 to 75 mcg per day (T3)
- Levothroid 50 to 200 mcg per day (T4)

WHEN TO ADMIT A PATIENT TO THE INPATIENT UNIT

- High risk for suicide
- A high risk for violence
- Severe psychosis
- Deterioration in self care

ALTERNATIVES FOR HOSPITALIZATION

- Use intensive outpatient program when the patient nee heck for 3-5 days a week

ALTERNATIVES FOR HOSPITALIZATION

- Outpatient treatment is needed when ther tion management and psyc

PSYCHOTHERAPY

- Most effective psychothe techniques:

- Depression: Interpersona cognitive/behavioral

PSYCHOTHERAPY

Manic and depression:

Meet with family and review stressors that lead up to the latest episode

EDUCATION OF THE PATIENT

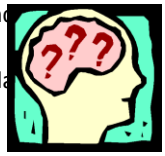
- Symptoms of the illness
- Maintain a journal of the symptoms
- Teach about the biological nature of illness

EDUCATION OF THE PATIENT

- Discuss medications
- Purpose
- Side effects
- Consistency of adhering to the regimen
- Discuss when medication adjustments are needed
- Discuss work and social schedules

EDUCATION OF THE PATIENT

- Discuss role of family and friend
  stressors
- Determine warning signs of rela
- Maintain good sleep hygiene



EDUCATION OF THE PATIENT

- Eat a healthy diet and exercise
- Use caffeine and alcohol moderately
- Discuss meaning of illness and issues surrounding the illness (impact on work, marriage, children, peers)

INTERVENTIONS

- Evaluate the patient's m
- Ability to sleep
- Eating patterns
- Energy level

INTERVENTIONS

- Evaluate the patient'
  others by behaving ir
  not cause later sham

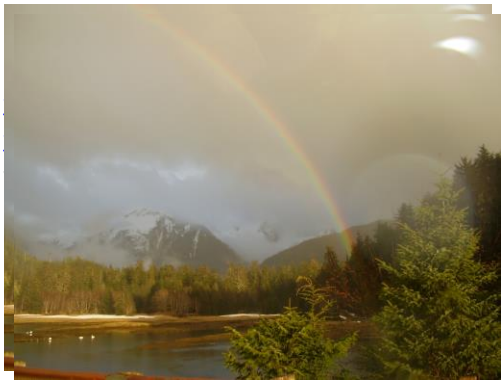
HARM-REDUCTION TECHNIQUES FOR MANIA

- Entrust a friend or family member his/her credit cards to prevent excessive spending.
- Give his/her keys to an appointed friend or family member to prevent traffic accidents or violations.
- Remove alcohol, drugs and firearms from the home
- Relieve the patient of child care responsibilities

FAMILY NEEDS

- The family members recognize symptoms patient to seek treat

-
-
-



BIBLIOGRAPHY

- American Psychiatric Association (2013) *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition. Washington, DC: American Psychiatric Association Press.
- Caseras, X., Lawrence, N. S., Murphy, K., Wise, R. G., & Phillips, M. L. (2013). Ventral striatum activity in response to reward: Differences between bipolar I and II disorders. *The American Journal of Psychiatry, 170*(5), 533-41. Retrieved from https://ezproxy.pgcc.edu/login?url=https://search-proquest-com.ezproxy.pgcc.edu/docview/1369312042?accountid=13315

- Cerit, D, Filizer, A, Tural, U, and Tufan, AE. (2012) Stigma: A core factor on predicting functionality in bipolar disorder. *Comprehensive Psychiatry* 53 (2012):484-489.
- Gumus, F., Buzlu, S., PhD., & Cakir, S., PhD. (2017). The effectiveness of individual psychoeducation on functioning and quality of life with bipolar disorder in turkey: A randomized controlled study. *International Journal of Caring Sciences, 10*(1), 490-502. Retrieved from https://ezproxy.pgcc.edu/login?url=https://search-proquest-com.ezproxy.pgcc.edu/docview/1896832893?accountid=13315

BIBLIOGRAPHY

- Kaplan, A. (2008). Task force proposes new bipolar guidelines. *Psychiatric Times, 25*(4), 1-8. Retrieved from https://ezproxy.pgcc.edu/login?url=https://search-proquest-com.ezproxy.pgcc.edu/docview/204645977?accountid=13315
- Lehr, S., & Schlenger, A. (2016). Creative strategies to enhance students' classroom learning in mental health. *Journal of Psychosocial Nursing & Mental Health Services, 54*(5), 41-48. doi:http://dx.doi.org.ezproxy.pgcc.edu/10.3928/02793695-20160420-06

BIBLIOGRAPHY

- Nierenberg, A. A., Friedman, E. S., Bowden, C. L., Sylvia, L. G., Thase, M. E., Ketter, T., . . . Calabrese, J. R. (2013). Lithium treatment moderate-dose use study (LiTMUS) for bipolar disorder: A randomized comparative effectiveness trial of optimized personalized treatment with and without lithium. *The American Journal of Psychiatry, 170*(1), 102-10. Retrieved from https://ezproxy.pgcc.edu/login?url=https://search-proquest-com.ezproxy.pgcc.edu/docview/1317509740?accountid=13315

- Post, R. M., Leverich, G. S., Kupka, R., Keck, P. E., McElroy, S. L., Altshuler, L. L., . . . Nolen, W. A. (2016). Clinical correlates of sustained response to individual drugs used in naturalistic treatment of patients with bipolar disorder. *Comprehensive Psychiatry, 66*, 146-156. doi:http://dx.doi.org.ezproxy.pgcc.edu/10.1016/j.comppsych.2016.01.009
- Rakofsky, JJ and Dunlop, BW. (2014) Risk vs reward Treating bipolar mania in the outpatient setting. *Current Psychiatry* 13(11): 39-46

BIBLIOGRAPHY

- Rahmani, F., Ebrahimi, H., Ranjbar, F., Razavi, S. S., & Asghari, E. (2016). The effect of group psychoeducation program on medication adherence in patients with bipolar mood disorders: A randomized controlled trial. *Journal of Caring Sciences, 5*(4), 287-297. doi:http://dx.doi.org.ezproxy.pgcc.edu/10.15171/jcs.2016.030
- Scott-Gurnell, K., Ezeobele, I., Blake, J., Gerondale, T., Sanches, M., Averill, P. M., & Soares, J. C. (2014). Psychopathological features during childhood and adolescence among adult bipolar patients: A retrospective study. *Comprehensive Psychiatry, 55*(3), 422-5. doi:http://dx.doi.org.ezproxy.pgcc.edu/10.1016/j.comppsych.2013.10.003

BIBLIOGRAPHY

- Sylvia, L. G., Peters, A. T., Deckersbach, T., & Nierenberg, A. A. (2012). Nutrient-based therapies for bipolar disorder: A systematic review. *Psychotherapy and Psychosomatics, 82*(1), 10-9. doi:http://dx.doi.org.ezproxy.pgcc.edu/10.1159/000341309
- Tanidir, C., & Uneri, O. S. (2015). Effective mood stabilization with olanzapine monotherapy in an adolescent with treatment resistant rapid cycling bipolar disorder. *Journal of Mood Disorders, 5*(4), 179. doi:http://dx.doi.org.ezproxy.pgcc.edu/10.5455/jmood.20150623063342

BIBLIOGRAPHY