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ARCHIVES OF Depression and Anxiety OPEN ACCESS JOURNAL

ISSN: 2455-5460 DOI: https://dx.doi.org/10.17352/ada

Mini Review

Managing anxiety disorders in bipolar patients

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Received: 09 June, 2023
Accepted: 19 June, 2023
Published: 20 June, 2023

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Keywords: Bipolar disorder; Anxiety disorders; CBT; Lamotrigine; Antidepressants

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Abstract

Anxiety disorders are among the main comorbidities encountered in patients with bipolar disease. Numerous clinical and epidemiological studies show an increased prevalence of anxiety pathologies (generalized anxiety disorder, social anxiety disorder, obsessive-compulsive disorder, panic disorder, and post-traumatic stress disorder) in bipolar subjects compared to the frequencies in the general population. Anxiety disorders are not without consequences on the evolutionary course of the mood disorder, including a significant reduction in euthymia time and less sensitivity to conventional medicinal therapies.

Introduction

Many psychiatric disorders exist in patients with Bipolar Disease (BD), such as anxiety, eating disorders, personality disorders, and drug addiction [1].

Anxiety disorders are a fairly common disorder in bipolar people. They are often associated with worsening bipolar disorder and a more difficult response to treatment. Anxiety disorders can precede the onset of bipolar disease and could be a risk factor to consider in the diagnosis of this disease. We usually talk about comorbidity, that is to say, the association of anxiety disorders with bipolar disorder [2]. It is particularly complicated to determine which is the chicken and which is the egg. Indeed, it is common to consult a person with an obvious anxiety disorder, so obvious that the physician often forgets to look for a mood disorder, it must be recognized that anxiety disorders are the trees that hide the forest that is bipolarity.

Epidemiology

Epidemiological and clinical data indicate high rates of anxiety disorders in patients with bipolar disorder [3]. Comorbid anxiety disorders have been reported at very different rates depending on the study [4]:

- 0.6% to 62.5% for panic disorder,
- 7.8% to 47.2% for social anxiety formerly called social phobia,
- 3.2%-35% for Obsessive-Compulsive Disorder (OCD),
- 7% to 38.8% for Post-Traumatic Stress (PTSD)
- 7% to 32% for generalized anxiety.

These percentages are surprising as their range is wide! This proves that the clinical significance of comorbid anxiety is poorly defined. However, we observe a greater severity of symptoms with serious dysfunctions when anxiety continues to be present, even when the mood is stabilized. High levels of anxiety symptoms have been associated with suicidality and substance abuse.

The study by Meier, et al. [5] looked at different anxiety disorders as potential risk factors for bipolar disorder, in a Danish population sample of over 3 million people. This sample included 9,000 bipolar people, who were followed for their associated anxiety disorders, including agoraphobia, generalized anxiety disorder, obsessive-compulsive disorder,

Citation: Bourin M (2023) Managing anxiety disorders in bipolar patients. Arch Depress Anxiety 9(1): 038-040. DOI: https://dx.doi.org/10.17352/2455-5460.000078

panic disorder, post-traumatic stress disorder, specific phobia, and social phobia.

The results of the study showed that patients suffering from anxiety disorders would be 9 times more at risk of developing bipolar disorders compared to the general population. This would be even more true for two types of anxiety disorders most closely associated with bipolar disorders, generalized anxiety disorder, and panic disorder. Patients with a diagnosis of generalized anxiety disorder are 12 times more at risk for bipolar disorder than the rest of the population and 10 times more at risk for people suffering from panic disorder.

Management of anxiety in bipolar patients

Most people feel anxious at times and have ups and downs. It is natural for a mood to change, and when the level of anxiety increases, along with a stressful or difficult event. But some people experience feelings of anxiety or depression or suffer from mood swings so severe and overwhelming that they interfere with personal relationships, work responsibilities, and day-to-day functioning. These people may have an anxiety disorder, bipolar disorder, or both. It is not uncommon for someone with an anxiety disorder to also have bipolar disorder. Many people with bipolar disorder will suffer from at least one anxiety disorder at some point in their lives [6].

The goals of treatment for patients with anxiety comorbid with BD are to achieve remission of symptoms and a return to baseline functioning [7]. Anxiety occurs frequently during a depressive episode, which partly reflects the prevalence of comorbid diagnoses of anxiety and mood disorders but does not explain the symptoms of anxiety occurring during euthymia [8]. Anxiety symptoms, may not go away with the resolution of the mood disturbance episode. This leads to a gradual decrease in the patient's proper functioning and quality of life, even during euthymia [9]. Residual anxiety symptoms pose a risk of less effective treatment for the mood disorder and may predict a relapse of mood symptoms. Residual anxiety symptoms, particularly uncontrollable worry, are a good predictor of depression relapse. It is accepted that the remission of anxiety symptoms in bipolar depression can be a protection against depressive relapses [10]. Diagnostic research and treatment of comorbid anxiety and BD remains an understudied area. Most published publications are descriptive in nature; there are few clinical trials related to the treatment of anxiety in bipolar patients [11].

Anxiety comorbidity significantly complicates the evolution of bipolar disorder and constitutes a major therapeutic challenge [12]. Despite the small number of studies available to date, the data converge in favor of an interest in atypical antipsychotics and lamotrigine in this particular indication. Obtaining a lasting thymic stability probably has an anxiolytic effect in itself, this remains the main objective of the management of anxious bipolar patients. Antidepressants, which are good anxiolytics, can be used when the patient is depressed, provided that the dosage is reduced [13]. Most often, anxiety requires the prescription of several psychotropic drugs, while monitoring the patient in a reassuring manner.

Nevertheless, it seems necessary in this context to offer a large place for non-drug measures, in order to best relieve the anxious complaint of these patients:

- Cognitive and Behavioral Therapies, often called CBT, which is a form of short-term psychotherapy [14].
- Family therapy, this form of therapy uses strategies to reduce the level of distress within a family that can either contribute to or results from an ill person's symptoms [15].
- relaxation techniques, these techniques can help people develop the ability to more effectively cope with stresses that contribute to anxiety and mood, as well as any associated physical symptoms. Respiratory training, progressive muscle relaxation, and exercise are some of the techniques [16].
- Interpersonal and social rhythmic therapy is effective for bipolar disorder, this treatment program emphasizes maintaining a regular schedule of daily activities and stability in personal relationships. Patients record the timing of their activities, their mood, and their levels of social stimulation. As treatment progresses, they work to maintain stable social rhythms (when to sleep, exercise, eat, etc.), anticipate events that might disrupt rhythms, and work out plans to maintain a stable mood and social rhythm [17].

Conclusion

Screening for anxiety disorders could help to identify people at risk for bipolar disease. If some of these disorders are diagnosed, appropriate treatments could then be put in place. Anxiety comorbidity significantly complicates the evolution of bipolar disorder and constitutes a major therapeutic challenge. It’s a particularly high prevalence fact that it cannot be neglected or ignored in current practice.

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