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Journal of Affective Disorders 98 (2007) 1 – 10

JOURNAL OF AFFECTIVE DISORDERS

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Review

Non-pharmacological treatments in the management of rapid cycling bipolar disorder

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Received 13 June 2005; accepted 15 May 2006
Available online 8 September 2006

Abstract

Background: Rapid cycling (RC) bipolar disorder is often treatment-resistant to pharmacotherapy. Non-pharmacological methods, however, are reasonable considerations in treatment refractory cases of bipolar patients. Thus, such methods may be useful in the management of RC, especially when drugs are not shown to be effective.
Method: This review is based on studies of all major non-pharmacological methods which are used in the management of bipolar disorder, by focusing on data regarding patients with a RC pattern of the illness.
Results: Regarding biological treatments, for electroconvulsive therapy and sleep deprivation, there exists some evidence that they might be efficacious in RC patients for acute treatment as well as for prophylaxis from recurrences. Light therapy has not been shown to be efficacious in RC, while no published data exist for transcranial magnetic stimulation and vagus nerve stimulation. The non-biological treatments include psychotherapeutic and psychosocial interventions; these have not been tried particularly on RC patients, but their use should be expected to contribute to the overall management of the RC pattern as it does to that of mood disorder in general.
Limitations: Many data on which this review is based are drawn from case reports or non-randomised trials.
Conclusions: Non-pharmacological methods, either biological or non-biological (psychotherapies and psychoeducation), may be applied in the management of RC patients. These methods might be used in combination with the administration of drug treatment, based on the clinical experience of the physician and the individual characteristics of the patient.

Keywords: Bipolar disorder; Rapid cycling; Treatment; Non-pharmacological

Contents

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0165-0327/$ - see front matter © 2006 Elsevier B.V. All rights reserved.
doi:10.1016/j.jad.2006.05.036

1. Introduction

Rapid cycling (RC) bipolar disorder is a variant of affective illness in which patients have experienced four or more episodes of mania, hypomania, or major depression in the last 12 months (Dunner and Fieve, 1974; American Psychiatric Association, 2000). The prevalence of RC among BP patients is between 13% and 20% (Coryell et al., 1992; Maj et al., 1994; Kupka et al., 2003) with a female preponderance of 72% or higher (Wehr et al., 1988; Bauer et al., 1994; Mackin and Young, 2004; Papadimitriou et al., 2005) and an overrepresentation of bipolar II patients (Akiskal et al., 2000; Calabrese et al., 2001a; Judd et al., 2003). RC is considered to be a course specifier of bipolar disorder (Maj et al., 1994; APA, 2000) and is usually transient with about 80% of RC patients not exhibiting this pattern after 5 years of follow-up (Coryell et al., 1992, 2003; Akiskal et al., 2000).

Although the treatment of RC should include the acute management of the presenting episode, it is also very important for treatment regimens to be configured to prevent relapse. In addition, addressing the external factors, which may be considered as potentially causing and maintaining RC, is of special consideration. For example, antidepressants, which are administered as a treatment for individual episodes of depression, should be used cautiously since there is evidence in various studies that they may lead to the acceleration of cycles, although this contention has been challenged based on the results of other studies showing a lower risk than initially reported, particularly if mood stabilizers are concomitantly administered (Angst, 1985; Altshuler et al., 1995, 2001, 2003a, 2006; Benazzi, 1997; Kilzieh and Akiskal, 1999; Coryell et al., 2003; Yildiz and Sachs, 2004; Bauer et al., 2005; Leverich et al., 2006). Equally important is to obtain detailed information about the lifetime course of the illness and construct a graphic representation of the episodes. Recording such an exhaustive history is a useful guide for the progress of treatment, plays an important role in clearly understanding the RC process of the individual patient and helps promote his/her better compliance with the treatment guidelines (Post et al., 1988).

Despite the existence of many drugs and their efficacy in the management of patients with bipolar disorder, the pharmacological treatment of RC does not seem to be effective enough (Maj et al., 1998; Goodwin, 1999; Sachs and Thase, 2000; Bowden et al., 2000; Calabrese et al., 2001a; Tondo et al., 2003; Koukopoulos et al., 2003). Thus, based mainly on empirical observations, many patients with RC are frequently prescribed various combinations of medicines, leading to high rates of polypharmacy (Frye et al., 2000; Post et al., 2000; Tondo et al., 2003; Altshuler et al., 2003b).

The 2002 and 2006 American Psychiatric Association guidelines for the pharmacological management of RC suggest that the use of antidepressants, classical or newer ones, should be done with caution in order to prevent a switch to mania; that classical antipsychotics should be carefully administered as they may also be responsible for cycle acceleration; and that effective mood-stabilizing treatment, often based on a combination of drugs, should be always in place (American Psychiatric Association, 2002; Hirschfeld, 2006). In spite of the implementation of well-planned drug treatments, however, RC is often difficult to manage, thus creating the need for other treatment interventions as well. These interventions may be biological (electroconvulsive therapy, sleep deprivation, light therapy, repetitive trancranial magnetic stimulation, vagus nerve stimulation) or non-biological (psychotherapies, psychoeducation) and are also used in patients with non-RC-resistant depression or treatment-refractory cases of bipolar illness.

For most patients with RC, depressive episodes prevail, and thus, the treatment of depression is one of the main clinical challenges in the management of RC bipolar disorder (Calabrese et al., 2001b). The specific antidepressant properties of all of the above-mentioned