Treatment of Mania and Psychosis

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Disclosures

Neither I nor my spouse/partner has a relevant financial relationship with a commercial interest to disclose.
Historical perspectives

• Hippocrates (Fourth Century BCE) describes melancholia as an excess of black bile
• Avicenna (980-1087 CE) describes melancholia and mania in his Canon of Medicine and suggest various herbal remedies
• Emil Kraepelin (1856-1926) classifies the major psychotic disorders into manic-depressive insanity and dementia praecox based on long term outcomes.
Diagnosis

- At least a week of abnormal and persistently elevated, expansive or irritable mood and abnormally and persistently goal-directed behavior or energy, associated with 3-4 of the following.
  - Inflated self esteem or grandiosity.
  - Decreased need for sleep.
  - Pressured speech.
  - Flight of ideas.
  - Distractibility.
  - Increased goal directed activity or agitation.
  - Excessive involvement in activities with a high potential for painful consequences.

- The mood changes are severe enough to cause marked impairment in social or occupational functioning (Not just transient changes).

- Evaluate for secondary causes of the mood disorder such as medical disorders, prescription medications or substances.
Psychosis

- Hallucinations
- Delusions
- Disorganization in speech and thought
- Disorganized or Catatonic behaviors
- Negative symptoms
Diagnostic and Treatment challenges:

• Full blown mania is rarely missed in clinical settings, however, hypomania is more difficult to identify

• Some reasons for misdiagnosis include
  – Limited insight of patients into mania/hypomania
  – Lack of systematic assessment of mania by clinicians
  – Stigma
  – Variability of age of onset and presentation
  – Misdiagnosis as unipolar depression
  – Psychiatric and medical comorbidities
  – Comorbid substance use disorders
  – Symptom overlap with other psychiatric conditions

Insight and Accepting Treatment

• Insight may be diminished during acute phases of mania and psychosis
• Lack of insight can become an obstacle to accepting treatment and treatment non-adherence

The role of the family

• Provide support for healthy behaviors.
• Listen to the individuals concerns.
• Remember that stigma is a serious obstacle to getting treatment.
• Keep an open line of communications with the clinicians treating the family member.
• Don’t hesitate to ask questions from the treatment team.
• Education, support, and advocacy for patients and families
  – DBSA (Depression and Bipolar Support Alliance) dbsalliance.org
  – NAMI (National Alliance on Mental Illness) nami.org
Treatment Options

• As mania/psychosis develop, the first question for the treatment team is safety
• Is the patient in need of hospitalization/partial hospitalization or can the condition be managed with regular clinic visits?
• Does the patient need to come in more frequently to see their clinician?
FDA approved treatments for acute mania

- **Atypical Antipsychotics**
  - Aripiprazole
  - Asenapine
  - Cariprazine
  - Olanzapine
  - Risperidone
  - Quetiapine
  - Ziprasidone

- **Mood Stabilizers**
  - Lithium
  - Divalproex
  - Carbamazepine

Treatment Options

• Lithium is the only agent that was developed specifically for bipolar disorder.
• All other treatments were initially developed for other conditions, then studied for effectiveness in bipolar disorder
  – Antipsychotics (Schizophrenia)
  – Mood stabilizers (Anti-epileptics)
  – Benzodiazepines (sedatives)
  – Antidepressants (MDD)
First line for treatment of mania

- **Monotherapy:**
  - Lithium
  - Quetiapine
  - Divalproex
  - Asenapine
  - Aripiprazole
  - Paliperidone
  - Risperidone
  - Cariprazine

- **Adjunctive therapy with Lithium or Divalproex:**
  - Quetiapine
  - Aripiprazole
  - Risperidone
  - Asenapine

Second line for treatment of mania

- Olanzapine
- Carbamazepine
- Olanzapine + (Lithium/Divalproex)
- Lithium + Divalproex
- Ziprasidone
- Haldol
- ECT

Third line for treatment of mania

- Carbamazepine/Oxcarbazepine + Lithium/Divalproex
- Chlorpromazine
- Clonazepam
- Clozapine
- Haloperidol + Lithium/Divalproex
- rTMS
- Tamoxifen
- Tamoxifen + Lithium/Divalproex

Long acting antipsychotics

- Administered in an injectable form once every 2 weeks, up to once every three months
- Not indicated for acute treatment of manic episodes
- Helps with improving medication adherence and preventing recurrence of episodes
- Aripiprazole, Fluphenazine, Haloperidol, Paliperidone, Risperidone.
Common Medication Side Effects (Lithium)

Common, mostly early on in treatment
- Sedation
- Weight gain
- Thirst/Urinating more frequently
- Nausea, loose stools, constipation
- Tremors

Adverse events from longer term treatment
- Thyroid and parathyroid dysfunction
- Kidney dysfunction
- Dermatological conditions (acne, psoriasis, hair loss)

Lithium Toxicity
- Drug interactions
- Dehydration
- Drug over dosage

Antipsychotics

• Sedation
• Weight gain and metabolic abnormalities
• Motor abnormalities

Anticonvulsants (Valproate, Carbamazepine)

• Sedation
• Weight and appetite changes
• Tremors, dizziness
• Effects on liver functioning
• Effects on blood cells (easy bruising, drop in white blood cells)
• Drop in blood sodium (Carbamazepine)
• Interactions with other medications (Carbamazepine)

Medication Monitoring

While on Antipsychotics,
- Check weight, monthly the first three months, then every three months
- Check fasting blood sugar (or HgA1c), BP every three months for a year, then annually.
- Check lipids after three months, then annually
- ECG and Prolactin, if clinically indicated

While on Lithium
- Serum levels every 3-6 months (or after dose changes)
- Kidney function every 3-6 months
- Weight, thyroid function and calcium after 6 months, then annually

While on Valproate or Carbamazepine
- Weight, blood count, liver functioning, electrolytes at least annually once on stable dose.
- Medication serum levels when clinically indicated

ECT treatment for bipolar disorder

• ECT has been in use since the 40’s
• Initially treatment was administered without anesthesia and with higher doses of electricity
• Modern treatments are administered with muscle relaxants and anesthesia
• 522 medication resistant bipolar patients (depressed, mixed, manic and catatonic)
• Almost 70% responded to ECT. Highest response rate was for catatonia (80.8%) and lowest for depression (68.1%)

Sleep and Mania

- It is well established that sleep loss can trigger mood episodes in bipolar disorder
- Specifically, sleep loss can trigger manic episodes in individuals with Bipolar type I disorder or female gender
- Sleep hygiene and regular sleep are an important part of recovery from mania

Psychotherapies

• Most helpful in depressive and maintenance phases of the illness

• During mania/hypomania the therapist will help with adherence to treatments and medications, developing daily routine and regular sleep patterns
Thanks for your attention!

Looking forward to your questions and comments.