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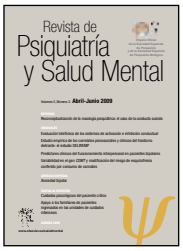

SPECIAL ARTICLE

Bipolar anxiety

Ansiedad bipolar

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Introduction

Anxiety is the forgotten problem of bipolar disorder. Nine of every 10 bipolar patients have a comorbid anxiety disorder in their lifetime.[1] This is equally true for bipolar I and bipolar II cases and this rate appears to be higher than anxiety comorbidity prevalence in major depression (50%)[2] or non-affective psychosis (63%).[3] Anxiety can reasonably be viewed as a core dimension of bipolar disorder[4] and anxiety symptoms often precede its onset.[5] Finally, anxiety is also a risk factor for increased suicide attempts and suicide completion in the evolution of bipolar disorder.[6,7]

Why is anxiety so common? The relationship between bipolar disorder and anxiety is not decided. Anxiety may be determined by shared risk factors or even as a secondary effect of the primary psychopathology. Alternatively, it may be a developmental accompaniment of bipolar disorder, preceding onset in the life history, but not having a direct role in bipolarity per se. Finally, anxiety symptoms may be a precursor required for the development and full expression of bipolarity. We will discuss here whether anxiety symptoms may mediate increased mood reactivity and intrinsic mood instability in bipolar disorder: a fuller description is available in Holmes, Geddes, Colom and Goodwin.[8]

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The role of imagery

We suppose a central role in bipolar disorder for involuntary, distressing mental images about the past or future that come to mind unbidden, typically with high levels of affect. For example, a patient may see in their "mind's eye" a detailed, vivid image of a highly stressful event such as harm coming to themselves. Conversely, they may vividly picture themselves in a casino doing brilliantly, winning at gambling. Imagery is now appreciated to be a critical process exacerbating states of normal and abnormal emotion[9] and can amplify emotion more than verbal (language-based) thinking. A hallmark of the bipolar phenotype is that it is an emotionally volatile disorder. It seems likely that imagery may serve as an emotional amplifier of a variety of mood states in bipolar disorder, and anxiety in particular.

Currently, direct evidence to support this imagery hypothesis remains limited. Mansell and Lam[10] found that remitted bipolar patients gave autobiographical memory responses to negative cue words in an even more over-general manner than a group of remitted unipolar depressed patients: the content of negative memories was predominantly anxious. Such over-general memories tend to be less image-based but indicative of suppressing intrusive images.[11] Tzemou and Birchwood[12] directly examined intrusive trauma imagery, in addition to over-general memory bias in bipolar I disorder, unipolar depression and controls. Both clinical groups showed an over-general memory bias compared to controls, and about half of both patient groups reported currently experiencing distressing traumatic memories. As we know from posttraumatic stress disorder (PTSD), such trauma memories and flashbacks take the form of vivid images. Greater over-general memory

bias was associated with fewer traumatic intrusions. Cognitive avoidance of emotional memories was postulated to maintain symptoms. However, additional non-trauma imagery was not explored (the experience of imagery was elicited using a PTSD-relevant instrument) and details of the other anxiety symptoms experienced by these patients were not described.

The consequences of anxiety

If, as we propose,[8] bipolar patients are particularly imagery-prone, then this leads to a number of testable predictions about bipolar anxiety. First, mental imagery acts rapidly to amplify emotion and, in bipolar disorder, the strength of this mechanism —in feedback terminology, the gain of the system —may help to explain a number of its key psychopathologies. Anxiety concerns apprehension of future threat, anxiety disorders have been clearly linked to pathological imagery e.g. flashbacks in PTSD or negative-self images in social phobia[13] (Figure). Thus an excess of threat-related imagery will fuel anxiety in bipolar disorder. Importantly for bipolar disorder, a similar cognitive mechanism could be engaged by positive mood states. The process of mood elevation remains insufficiently explained in bipolar disorder at a cognitive level. Individuals can experience intense positive as well as negative imagery.[14,15] Mood elevating imagery (e.g. winning at gambling, as above) allows us to "pre-experience" what attaining a future desired goal would be like, which in turn may fuel mania and strengthen the interpretation that there is a real positive goal state to be achieved and acted on[16] (Figure). One could equally imagine a roll for anxiety in mixed states, where we might predict more ambiguous mediating imagery to generate both negative and positive mood amplification. Second, bipolar co-morbidity with both substance misuse, pathological gambling and even suicide could have common roots in imagery.[17-19] Third, mood instability is another poorly understood characteristic of bipolar disorder.[20,21] Imagery has the immediacy and completeness that could account for rapid changes to positive or negative mood in patients who are between full episodes. Our suggestion is that this primarily provides an important mechanism in clinically euthymic patients rather than just in full-blown episodes. As such it may be a key locus for the risk of relapse and, accordingly, for its prevention.

In summary, we suggest that bipolar patients may be particularly imagery-prone. The catalytic effect of imagery mechanisms on emotion could contribute to the extremes of mood intensity in bipolar disorder, as well as to rapid changes in daily mood. An imagery hypothesis suggests there may be a powerful impact on pre-experiencing the future and on increasing action likelihood. Furthermore, it links with the unaccountably widely co-occurring features of bipolar anxiety. So, could this re-formulation of the role of imagery and anxiety generate new approaches to treatment? We believe so.

Medication remains a critical treatment component for bipolar disorder. However, its mechanism of action is poorly understood at a systems level. Improving the cognitive theory of bipolar psychopathology may drive a better understanding of the mechanisms of drug action as has happened for antidepressants.[22] However, it is obviously in the development of psychological treatments where we are most optimistic. The absence of formal evidence on which to base drug treatment of bipolar anxiety is paralleled by a corresponding absence of formal investigation of psychological treatments targeting bipolar anxiety. Cognitive behaviour therapy (CBT) is a preferred treatment for several anxiety disorders including panic disorder.[23,24] However, in bipolar disorder, the value of CBT remains unproven. One major trial[25] was disappointingly negative (see also).[26] CBT for bipolar disorder has been pragmatic in its development. Any theory has been focused on depression and mania,

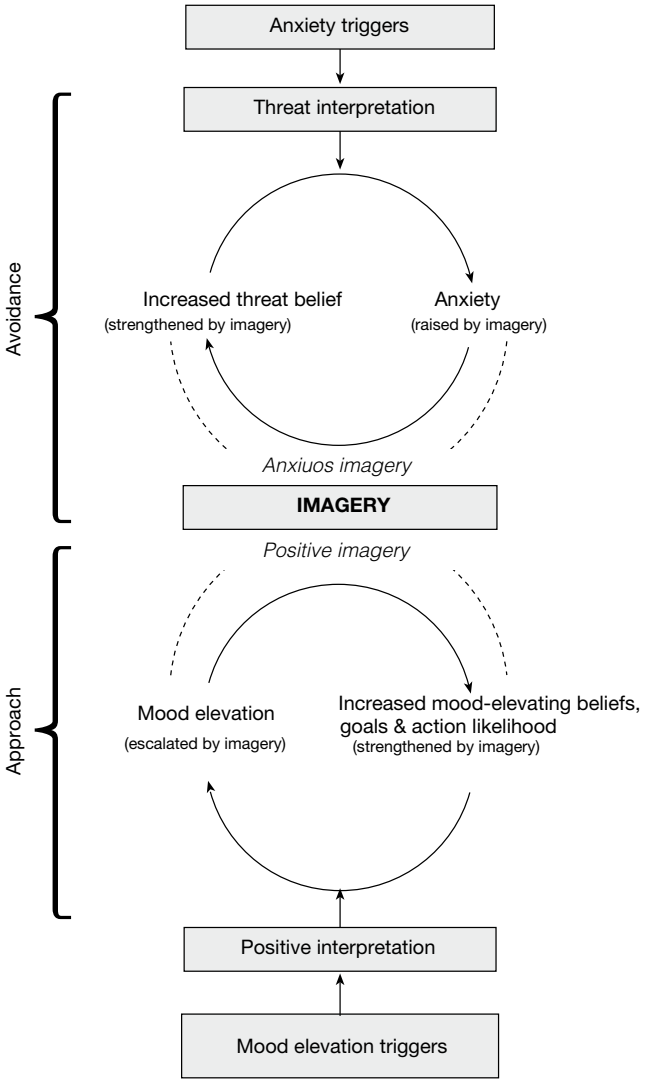

Figure A model of the role of mental imagery on emotion within bipolar disorder: imagery amplifies anxiety and mania (reproduced with permission of the editor of *Behaviour Research and Therapy*).

so cognitive aspects of anxiety do not appear to have been adequately explored at all. Other evidence-based psychosocial therapies for bipolar disorder such as family focused therapy,[27,28] interpersonal social rhythm therapy[29,30] and psychoeducation[31] do not specifically target anxiety processes.

One way to develop more successful theoretically-driven psychological treatments is through research on cognitive processes that cross diagnostic boundaries.[32] If the presence of "affective, intrusive mental imagery" proves to be much more prevalent and important than is currently appreciated in bipolar disorder, it will provide a much needed theoretical and practical focus. Imagery is the language of immediate emotion, and bipolar is an emotionally volatile disorder — the two seem ripe to converge.

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