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CLINICAL CARE

BIPOLAR DISORDERS WILEY

The COVID-19 pandemic is a crisis and opportunity for bipolar disorder

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The ongoing COVID-19 pandemic has to date infected more than 1 million people and led to tens of thousands of deaths across the globe. Thus, many governments have imposed regional or national mass shelters-in-place in an effort to slow its rapid spread. In this global health emergency, special attention should be paid to the potential impact of the measures taken to combat the pandemic on patients with bipolar disorders (BDs).

Shelter-in-place and quarantine are key public health tools, yet they have high psychological and economic costs. They require sacrificing daily routines and public/personal social encounters that enhance health and quality of life and provide emotional support. Even in the general population, the length of social isolation and the constrained physical space in which isolation takes place can be associated with a wide range of adverse psychological effects, including depression, lowered self-esteem, alienation, and helplessness.[1] Anger, clinical anxiety, and posttraumatic stress disorder can persist years after the end of the isolation, as indicated by literature on quarantine.[1] We say this not to undermine the importance of these measures, but rather to underscore the potential consequences for vulnerable and marginalized populations.

The impact could be even more severe and long-lasting in persons with BD. The present emergency is disrupting both public and private mental health services, and most patients cannot access outpatient care. Under threat are treatment continuity, alliance and adherence, and patient-driven recovery progress—while the pandemic simultaneously escalates stress levels.

Alarming news reports about the economic and human costs add heightened stress at the same time as social distancing measures reduce opportunities for exercise, sunlight exposure, participation in meaningful activities and social engagement. Job loss and financial uncertainty add more strain, potentially triggering anxiety as well as mood symptoms—again, in a population already vulnerable.

The regular rhythm of a healthy life becomes hard to maintain as classes are canceled or moved online, and work-at-home policies are implemented. Sheltering-in-place can shave away the *zeitgebers* that help keep sleep and activity stable and promote engagement with community.

People with BD are likely to be especially susceptible. BD has high comorbidity with obesity, diabetes mellitus, coronary heart disease, and obstructive pulmonary disease, as well as smoking and substance use.[2] These factors and related physical illnesses compromise immune functioning and heighten risk for severe acute respiratory syndrome (SARS-CoV-2) if one is infected with the coronavirus. Smoking and cardio-pulmonary disease are also common comorbidities observed among those who perish from COVID-19.

Moreover, current treatment protocols for COVID-19 are rapidly evolving, incurring risk for drug interactions, especially in patients being managed with complex regimens. Of course, BD itself frequently involves polypharmacy. Because no specific antiviral treatment has been developed, current treatment options include off-label use of azithromycin, lopinavir–ritonavir, and chloroquine/

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hydroxychloroquine. However, using these medications with patients with BD requires careful attention because of interactions between azithromycin/lopinavir–ritonavir and the commonly recommended medications for BD. Of real concern, the possible adverse psychiatric effects of chloroquine/hydroxychloroquine include psychosis, mood change, mania, and suicidal ideation.[3] Chloroquine may exacerbate BD.

Social stigma flares when societies are under stress, with a malign eye falling on people associated with high-risk groups as well as on anyone considered "different." BD is already prone to stigmatization and will undoubtedly take a second hit when people with BD also contract COVID-19. People with COVID have been ostracized; the perceived stigma of having two burdens could not just aggravate a sense of isolation but provoke hostility instead of support.

Yet, crises are also times of opportunity. We can learn from examples of resilience and rethink and adapt our ways of working. Two months after the start of China's COVID-19 lockdown, Chinese mental health clinicians are now seeing that if patients move from situations with insecure housing to more secure housing, they report more daily regulation and mood stability or improvement. These positive trends occur in patients returning to live with their families, as well as in hospital settings. Similarly, people with lived experience of BD engaged with the Collaborative RESearch Team in Bipolar Disorder (CREST.BD) network report silver linings, and during the *TalkBD Online Meetup: Staying Mentally Well During COVID-19* (March 20, 2020) forum found that being proactive about protecting routine and doubling down on wellness tools prevented social distancing from triggering deterioration.

The pandemic forces a rethinking of how best to improve access to and implementation of enhanced psychological and psychiatric intervention services specific to BD. These should include (but not be limited to) home visits with physical distancing measures in place,[4] telepsychiatry assessment (eg, https://effectivechildtherapy.org/assessment-center) and/or treatment, online prescription and medicine express delivery, telepsychology management interventions, teletherapy, online psycho-education programs, online mindfulness-based interventions, online sleep hygiene resources and apps, and facilitating access to existing (or development of) phone and online support lines staffed by mental health professionals trained in treating BD. The emerging number of apps and m-health resources may play a crucial positive role.[5] A great need exists to train and support clinicians to go to where people already are online.

Despite the dramatic consequences of the COVID-19 pandemic, this emergency situation provides both the opportunity for (a) broader and more in-depth understanding of BD patients' psychological functioning and (b) development and implementation of mental health policies and services. A prompt and effective response holds the potential to ameliorate the personal and societal risks associated with poor mental health, with the added benefit of saving private and public money. These efforts offer the opportunity to address mental illness stigma and potentially ameliorate internalized stigma by fostering a society where they are demonstrably valued and their health needs are supported. Indeed, appropriate use of technology can help to maintain human connections despite physical distance. The COVID crisis is a wave propelling sweeping changes in policy, access, delivery, and attitudes. When it recedes, the landscape for the treatment of BD will have changed. There will be damage and loss, but also opportunities to learn—as well as changes in service delivery that could turn into significant advances in service delivery and outcomes.

Key message

On top of public health and economic costs, the pandemic adds strain, disrupting daily routines and service delivery. Bipolar disorder can increase vulnerability, complicate treatment, and heighten interpersonal stigma. Yet there are successes when people proactively improve social connections, prioritize self-care, and we learn to use mobile and telehealth effectively.

Learning points

- Bipolar disorder patients who move from situations with insecure housing to more structured (familiar or hospital) settings report more regular daily life than before, and their mood stays stable or improves.
- The use of current treatment options for SARS-CoV-2 with patients with bipolar disorder requires careful attention because of both interactions with the commonly recommended psychotropic medications and the risk that some treatments may worsen mood symptoms and instability.
- Informed and thoughtful use of technology may play a crucial positive role in providing cost-effective and tailored interventions.

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CONFLICT OF INTEREST

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