



Editorial comment

Migraine headache and bipolar disorders: Common comorbidities



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1. Awareness of bipolar disorder when treating migraine headache

In this issue Leo and Singh [1] present interesting findings on the relationship between migraine headache and bipolar disorder. The connection between chronic pain and mental disorders is well known from the literature, and previous studies have consistently shown that the combination of migraine headache and depression is rather common. This paper adds to our knowledge by its findings that comorbid bipolar disorder also is often seen, and that it seems to be the second most prevalent comorbid mental disorder after major depressive disorder among migraine headache sufferers. As the authors state, the finding of increased prevalence of bipolar disorder in migraine headache does not say anything about the underlying mechanisms, and at this point of time these remain speculative [1].

2. Bipolar or major depressive disorder?

There are two main classes of affective disorders; bipolar and depressive disorders. The life time prevalence of bipolar disorders is about 2%, while depression hits a much larger number [2]. Bipolar disorders are classified in two categories. The diagnosis of bipolar I disorder requires at least one full blown manic episode, and this is diagnostically often quite clear-cut. In bipolar II the elevated episode is hypomania. The diagnosis of hypomania is often not so obvious. The differential diagnosis between bipolar II and borderline personality disorder, both more common among women, may be complicated [2].

It is important for the clinician considering prescription of antidepressant medication to a patient with migraine headache to be aware of the possibility that the depressive episode may be part of a bipolar disorder. Unrecognized bipolar disorder is not uncommon [3]. Treatment of bipolar depression is different from that of unipolar depression. While antidepressant medication is the first choice in unipolar depression, this is much more controversial in bipolar depression. The therapeutic effect is uncertain, and the risk of negative effects is substantial. There is a risk of eliciting a manic episode, and the issue has also been raised whether the use of

antidepressant medication in bipolar disorder may lead to higher frequency of affective episodes, so called rapid cycling, which is an unhealthy course of the disease. For the moment we have no reliable ways of diagnosing whether a depressive episode is the first sign of bipolar disorder. The perhaps most useful approach is to ask about family history. Bipolar disorder often runs in families, and it is one of the most hereditary mental disorders. And we can ask our patients to be aware of the possibility that antidepressant medication may precipitate a manic or hypomanic episode, and to take contact if they fear that this is happening. But we have no secure ways of predicting whether the depressed person in front of us later will develop manic or hypomanic episodes.

3. A broader perspective on treatment: CBT, life style changes, and regular exercise

Treatment of comorbid disorders with combinations of medication increases the possibility of side effects and drug interactions. One way of dealing with this is to use other forms of treatment in addition to the pharmacological. In the management of mental disorders, various forms of psychological treatments are available. Cognitive behavioural therapy (CBT) is by far the most studied and best documented, but also other forms show almost similar effect sizes [4]. In the treatment of a major depressive episode, antidepressant medication and CBT fare about equal, but the relapse rate is lower among those who have received CBT [5]. Also in bipolar disorder CBT is documented to be effective [6]. There is also emerging evidence for the usefulness of CBT in the management of chronic pain, also migraine and other forms of headaches [7,8]. CBT may therefore be useful both for the pain and the comorbid mental disorder. And even if people do not develop comorbid mental disorders, many experience substantial levels of mental distress following years with pain, and psychological methods may be useful here as well. Recent studies argue for a broader perspective in the treatment of long lasting pain [9].

CBT is intuitively easy to understand, and the basic principles are not too complicated. The method is therefore possible to learn also for doctors from outside psychiatry. In Norway there has been a great interest in learning CBT among doctors dealing with chronic pain, and also general practitioners find this approach to be useful [10].

Another important topic for people living with long lasting or recurring disorders is lifestyle. Keeping the structure of the day with regular meals and sleeping at night is beneficial for people with

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mental disorders and for those with migraine [11]. Among lifestyle habits regular physical exercise has been most studied. People with mental disorders in general are sedentary compared to the general population. Starting to exercise is often useful, and the usefulness of exercise is well documented in depression and anxiety disorders [12]. Exercise is also useful in chronic pain. Lumbar pain has been most focused, but recent studies indicate that it is also useful in migraine [13]. This field of research is in an early phase. Exercise intervention studies involving people with long lasting pain disorder alone or in combination with mental disorders are warranted. For these common disorders self-help methods are important, as the health care system never can meet the need for treatment in the population.

4. Psychosocial interventions and self-help strategies in comorbid pain and mental disorders

Comorbid mental disorders are common among people with long lasting pain, and depressive and bipolar disorders are most often seen [1]. Psychosocial interventions and self-help strategies are useful for both conditions, and may reduce the chances for negative consequences of drug combinations.

References

- [1] Raphael J, Singh J. Migraine headache and bipolar disorders comorbidity: a systematic review of the literature and clinical implications. *Scand J Pain* 2016;11:136–45.
- [2] American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. Arlington, VA: American Psychiatric Association; 2013.
- [3] Hughes T, Cardno A, West R, Marino-Francis F, Featherstone I, Rolling K, Locker A, McLintock K, House A. Unrecognised bipolar disorder among UK primary care patients prescribed antidepressants: and observational study. *Br J Gen Pract* 2016;66:e71–7.
- [4] Cuipers P, Karyotaki E, Weitz E, Andersson G, Hollon SD, van Straten A. The effects of psychotherapies for major depression in adults on remission, recovery and improvement: a meta-analysis. *J Affect Disord* 2014;159:118–26.
- [5] Cuipers P, Berking M, Andersson G, Quigley L, Kleiboer A, Dobson KS. A meta-analysis of cognitive-behavioural therapy for adult depression, alone and in combination with other treatments. *Can J Psychiatry* 2013;58:376–85.
- [6] Swartz HA, Swanson J. Psychotherapy for bipolar disorder in adults: a review of the evidence. *Focus (Am Psychiatr Publ)* 2014;12:251–66.
- [7] Christiansen S, Jürgens TP, Klinger R. Outpatient combined group and individual cognitive-behavioral treatment for patients with migraine and tension-type headache in a routine clinical setting. *Headache* 2015;55:1072–91.
- [8] Harris P, Loveman E, Clegg A, Easton S, Berry N. Systematic review of cognitive behavioural therapy for the management of headaches and migraines in adults. *Br J Pain* 2015;9:213–24.
- [9] Gaul C, Liesering-Latta E, Schäfer B, Fritsche G, Holle D. Integrated multidisciplinary care of headache disorders: a narrative review. *Cephalalgia* 2015, pii:0333102415617413 [Epub ahead of print].
- [10] Aschim B, Lundevall S, Martinsen EW, Frich JC. General practitioners' experiences using cognitive behavioural therapy in clinical practice: a qualitative study. *Scand J Prim Health Care* 2011;29:176–80.
- [11] Woldemanuel YW, Cowan RP. The impact of regular lifestyle behavior in migraine: a prevalence case-referent study. *J Neurol* 2016 [Epub ahead of print].
- [12] Martinsen EW. Physical activity in the prevention and treatment of anxiety and depression. *Nord J Psychiatry* 2008;62:25–9.
- [13] Irby MB, Bond DS, Lipton RB, Niclas B, Houle TT, Penzien DB. Aerobic exercise for reducing migraine burden: mechanisms, markers, and models of change processes. *Headache* 2015, <http://dx.doi.org/10.1111/head.12738> [Epub ahead of print].