Behavioral Health 101: Bipolar

For Healthcare Providers
Learning Objectives

- Recognize symptoms of bipolar disorders
- Name 2 screening tools for bipolar disorders
- Identify 2 medications that are recommended for bipolar disorders
- List 2 treatment options for individuals who could have bipolar disorders
- Apply learning in an exercise utilizing screening options and identifying treatment options
Role of PH Providers in Treating BH

Only 20% of adult clients with mental health disorders are seen by BH providers.
Clients often prefer and receive treatment in primary care settings.

60% of premature death in persons with Schizophrenia are due to medical conditions such as cardiovascular, pulmonary, and infection diseases.

(American Hospital Association, 2014; Unützer, Harbin, Schoenbaum, & Druss, 2013)
Role of PCPs in Suicide Prevention

- 75% of individuals who die by suicide are in contact with a primary care physician in the year before their death
- 45% do so within one month of their death
- Only 20% of these patients saw a mental health professional in the preceding month
- 62% of antidepressant prescriptions in the U.S. are written by generalists (internists, pediatricians, PCPs)

Integrated Healthcare

Systematic integration facilitates the communication and coordination of:

- Physical healthcare
- Behavioral healthcare
- Substance use disorder treatment

Integrated care promotes a cohesive service delivery system & better continuity of care.

(SAHMSA, n.d.)
Common Disorders

• Depression
• Bipolar Disorders
• Anxiety Disorders
• Posttraumatic Stress Disorder
• Substance Use Disorders
• Schizophrenia & Psychotic Disorders
“Which of my feelings are real? Which of the me's is me? The wild, impulsive, chaotic, energetic, and crazy one? Or the shy, withdrawn, desperate, suicidal, doomed, and tired one? Probably a bit of both, hopefully much that is neither.”

— Kay Redfield Jamison, An Unquiet Mind: A Memoir of Moods and Madness
Normal Moods

Upper limit of “normal” mood (happiness, joy) - Mania

Hypomania

“Good times”

“Bad times”

Lower limit of “normal” mood (sadness, grief) - Subsyndromal depression

Major depression
Bipolar Disorder Types

Three Primary Types:

• Bipolar I
  o Full manic episode
  o No depressive episode required

• Bipolar II
  o Hypomaniac episode
  o At least one depressive episode required

• Cyclothymic Disorder
  o Two years of symptoms (hypomaniac and depressive)
  o Does not meet criteria for mania or depression

(APA, 2013)
Bipolar I

Upper limit of “normal” mood (happiness, joy)

Hypomania

Mania

“Good times”

“Bad times”

Lower limit of “normal” mood (sadness, grief)

Subsyndromal depression

Major depression

Upper limit of “normal” mood (happiness, joy)

Hypomania

Mania

“Good times”

“Bad times”

Lower limit of “normal” mood (sadness, grief)

Subsyndromal depression

Major depression
Bipolar I - Mania

For at least one week (or if hospitalized):

• Inflated self-esteem (overconfidence, feeling “high”)
• Decreased need for sleep (e.g. 3 hours)
• More talkative than usual
• Racing thoughts
• Distractability
• Increased goal-directed activity
• Risky behaviors w/ potential consequences
  • Sexual indiscretions
  • Shopping sprees
  • Gambling or foolish investments with savings

(APA, 2013, p. 124)
Bipolar I - Symptomology
## Bipolar II

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Bipolar II - Hypomania

For at least 4 days:
Expansive, elevated or irritable mood
Decreased need for sleep (e.g. 3 hours)
More talkative than usual
Racing thoughts
Distractibility
Increased goal-directed activity
Risky behaviors w/ potential consequences
Major depressive episode (past or current)

(APA, 2013, pp. 132-133)
Screening Tools

Bipolar Disorders

Mood Disorder Questionnaire (MDQ)

CIDI-based Bipolar Disorder Screening Scale 3.0
Screening Questions

Opening question(s)

• “Have you had periods of feeling so happy or energetic that your friends told you were talking too fast or that you were too ‘hyper’?"

• “Have you ever had a period lasting several days where most of the time you were so grouchy or irritable that you started arguments, shouted at people, or hit people?”

(Carlat, 1998; CQAIMH, 2007)
Mood Disorder Questionnaire (MDQ)

- Best for screening bipolar I
- 5 minutes to administer
- “Yes” or “No” questions
- NOT for diagnosing
- Free to use
  (http://www.integration.samhsa.gov/images/res/MDQ.pdf)

(Hirschfield, 2002)
CIDI-based Bipolar Disorder Screening Scale 3.0

- Developed by World Health Organization
- Screens for bipolar I and II
- 3 minutes to administer
- “Yes” or “No” questions
- NOT for diagnosing
- Free to use (http://www.cqaimh.org/pdf/tool_cidi.pdf)
Treatment for Bipolar Disorders

**Primary treatments**
- Medication
- Psychotherapy

**Other treatments**
- Electroconvulsive therapy (ECT)
- Psycho education
- Family education

Long-term, continuous treatment required

(NIMH, 2012)
Medications – Mood Stabilizers

- Lithium
- Depakote
- Lamictal
- Tegretol
- Neurontin
- Topamax
- Trileptal
Medications – Atypical Antipsychotics

- Zyprexa
- Ability
- Seroquel
- Risperdal
- Geodon
Group Activity

- **Healthcare professional**
  - Interviews patient with the screening questions
  - Completes either a verbal MDQ or CIDI 3.0 or hands to patient

- **Patient**
  - Gets interviewed and answers “yes” to one of screening questions
  - Answers MDQ or CIDI 3.0 however they want to

- **Observer**
  - Evaluates interviewer
  - Times interaction
  - Gives feedback to interviewer
  - Asks interviewer what they would do
  - Rotate roles 7 minutes for each round
Process

How difficult was it to conduct the screening?
How long did it take to conduct the screening?
What decisions did interviewers make after the screening?
How could you use what you’ve learned for integrated patient care in your practice?
What Questions Do You Have?
Learning Objectives Revisited

- Recognize symptoms of bipolar disorders
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Reflection

• What are two or three of the important things you’re taking away from this training?
• What changes will you make in your practice as a result of this training?
Parting Thought

“Never give up on someone with a mental illness. When ‘I’ is replaced by ‘We’, illness becomes wellness.”

Shannon L. Alder
References

References Continued…


• Gold, K. J., Kilbourne, A. M., & Valenstein, M. (2008). Primary care of patients with serious mental illness: your chance to make a difference: a primary care visit may lead to regular care of side effects and comorbidities, especially if you coordinate care. Journal of Family Practice, 57(8), 515-526.


References Continued...


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Resources