



**AIMS CENTER**  
**W** UNIVERSITY *of* WASHINGTON  
Psychiatry & Behavioral Sciences

Advancing Integrated Care for Over 20 Years

# Bipolar Disorder in Primary Care Settings



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# Goals and Objectives

- Describe an approach to assessment of bipolar disorder.
- Educate and engage patients in developing a treatment plan to target bipolar disorder in primary care
- Recommend and manage evidence-based psychiatric medications used to treat bipolar disorder.



## Evidence Base

- Comparison of Teleintegrated Care (TCC) and Telereferral Care (TER) for Treating Complex Psychiatric Disorders in Primary Care
  - Patients with bipolar disorder or PTSD were randomized to receive TCC or TER, significantly and substantially improved outcomes were observed in both groups.



# Case 1: Ms. R

- 33 y/o woman presented as a new patient to primary care clinic
  - Reported two-year history of depressed mood, anhedonia, and irritability
  - No previous psychiatric care
  - Initially diagnosed with MDD and treated with trials of bupropion and then sertraline
    - No improvement in symptoms → referred to Collaborative Care
- PHQ-9: 15/27
  - Moderate–severe depressive symptoms
  - 0 for Question 9
- GAD-7: 12/21 (moderate anxiety symptoms)

What other history would you want to know?  
What other screeners would you consider using?



# CIDI-3—Part 1

The first part of the CIDI-3 consists of asking two stem questions. If either Question 1 or Question 2 is positive, continue with the criterion B Screening Question. If both are negative, then the measure is negative and the patient does not likely meet the criteria for bipolar disorder.:

## **Euphoria Stem Question:**

1. Some people have periods lasting several days when they feel much more excited and full of energy than usual. Their minds go too fast. They talk a lot. They are very restless or unable to sit still and they sometimes do things that are unusual for them, such as driving too fast or spending too much money. Have you ever had a period like this lasting several days or longer?

*If this question is endorsed, the next question (Irritability Stem Question) is skipped and the respondent goes directly to the Criterion B screening question.*

## **Irritability Stem Question:**

2. Have you ever had a period lasting several days or longer when most of the time you were so irritable and grouchy you either started arguments, shouted at people or hit people?
3. People who have episodes like this often have changes in their thinking and behavioral at the same time, like being more talkative, needing very little sleep, being very restless, going on spending sprees, and behaving in many ways they would normally think inappropriate ways they would normally think inappropriate. Did you ever have any of these changes during your episodes of being excited and full of energy or very irritable or grouchy?



# CIDI-3—Part 2

**Think of an episode when you had the largest number of changes like these at the same time. During that episode, which of the following changes did you experience?**

1. Were so irritable that you either started arguments, shouted at people or hit people?
2. Did you become so restless or fidgety that you paced up and down or couldn't stand still?
3. Did you do anything else that wasn't usual for you – like talking about things you would normally keep private, or acting in ways that you would usually find embarrassing?
4. Did you try to do things that were impossible to do, like taking on large amounts of work?
5. Did you constantly keep changing your plans or activities?
6. Did you find it hard to keep your mind on what you were doing?
7. Did your thoughts seem to jump from one thing to another or race through your head so fast you couldn't keep track of them?
8. Did you sleep far less than usual and still not get tired or sleepy?
9. Did you spend so much more money than usual that it caused you to have financial trouble?

# questions positive	Risk of bipolar
9	Very high: ≥80%
7–8	High: 50–79%
6	Moderate: 25–49%
5	Low: 5–24%
0–4	Very low: <5%

# DSM-5-TR Diagnostic Conceptualization of Bipolar Disorder

	Manic	Manic w/mixed features	Depressed w/mixed features	Depressed
<b>Core</b>	Elevated or irritable mood + energy or activity	Elevated or irritable mood + energy or activity	Depressed mood or loss of interest	Depressed mood or loss of interest
<b>Manic symptoms</b>	>3 symptoms	>3 symptoms	>3 symptoms	N/A
<b>Depressed symptoms</b>	N/A	>3 symptoms	>5 symptoms	>5 symptoms



# Additional Diagnostic Considerations

- Peak incidence of BP-I and BP-II occurs between 12 and 30 years of age
- Women more likely to experience mixed mania and manic switches during antidepressant treatment
- ~22% of bipolar patients have additional somatic condition
- 39%: second psychiatric condition (of that, 2/3 are related to substance use)
- Lifetime prevalence of suicide attempts: up to 30%



# Bipolar I vs Bipolar II

Symptom Criteria	Bipolar I Disorder	Bipolar II Disorder
Manic episode(s)	Yes	No
Hypomanic episode(s)	Commonly occur, but not required	Yes
Major depressive episode(s)	Usually occur, but not required	Yes
Mixed features	May occur	May occur
Anxious distress	May occur	May occur
Rapid cycling	May occur	May occur
Psychotic features	May occur	May occur
Catatonia	May occur	May occur



## Case 1: Ms. R, Part 2

- CIDI-3: Endorsed prior experience with irritability and 7 associated symptoms from Criterion B symptoms
  - 50–80% likelihood
  - Reported an episode 1 year prior with all symptoms 8 symptoms, lasted ~2 weeks
    - No substances during that time (previously used cannabis, but not in last 3 years)
- Family history: Father with bipolar symptoms

What do you think the most likely diagnosis is?  
What treatment would you consider?



# First & Second-Line Medications for Bipolar Depression

- First-line medications:
  - Monotherapy with quetiapine or lurasidone
- Second-line medications: If first-line ineffective or intolerable, next-step options include:
  - Olanzapine plus fluoxetine
  - Valproate (divalproex) monotherapy
  - Combination therapy with quetiapine or lurasidone plus lithium or valproate
  - Combination therapy with lithium plus valproate or lamotrigine

## **Optimize dose of antimanic drug**

- Check serum concentrations
- Increase medication dose to at least the minimum dose and consider higher doses



# Other Medications for Bipolar Depression

- Third-line medications: If second-line ineffective or intolerable, next-step treatment options include:
  - Monotherapy with lamotrigine, lithium, or olanzapine
  - Monotherapy with carbamazepine or cariprazine
  - Combination therapy with olanzapine plus lithium or valproate
  - Other antimanic drug combinations (e.g., lithium plus carbamazepine)
  - Combination therapy with lithium or valproate plus antidepressant like SSRI (e.g., fluoxetine) or bupropion
  - Combination therapy with second-generation antipsychotic (usually quetiapine, lurasidone, or olanzapine) plus antidepressant
- Treatment-refractory patients: Electroconvulsive therapy (ECT)



# Treatment for Bipolar II Depression

- Very few studies focused on treatment of BP-II depression
  - Closely aligned with those for BP-I depression
  - Empirical support for quetiapine monotherapy



## Case 1: Ms. R, Part 3

- Doing well for one year, but decided wanted to get pregnant and stopped all medications
- Presents to clinic with increased irritability that caused her arguments with spouse and a coworker, difficulty concentrating, decreased need for sleep, and recent purchase of cruise not previously discussed with spouse
  - Mildly pressured speech and difficulty focusing on reporting her recent history
  - Spouse is with her and concerned about current symptoms

What would be your diagnosis? What would be your approach to treatment?

Once her mood is stable, how would you approach maintenance?



# Medications for Bipolar Mania or Mixed

- First-line monotherapy for hypomanic or mild-to-moderate manic episodes:
  - risperidone or olanzapine
- Reasonable alternatives:
  - aripiprazole
  - asenapine
  - carbamazepine
  - cariprazine
  - haloperidol
  - lithium
  - paliperidone
  - quetiapine
  - valproate
  - ziprasidone
- Drugs no more effective than placebo: lamotrigine, lincarbazepine, oxcarbazepine, topiramate, verapamil



## Meds for Bipolar Mania or Mixed—Additional Considerations

- Medications with previous positive effect
- Renal disease: Generally avoid lithium
- Liver disease: Generally avoid valproate
- Sensitivity to extrapyramidal symptoms: Generally avoid aripiprazole and risperidone
- Obesity: Generally avoid olanzapine, quetiapine, and risperidone
- Women of childbearing age: Generally avoid valproate



# Medication Adherence

## Prescribing Together: Bipolar Disorder

- Context
  - Consider psychopharmacology in context of positive clinician–patient relationship
  - Consider active collaboration, accessibility, empathy
  - Focus on concordance (agreement between two parties)
  - Importance of “intelligent extension of hope”
- Strategies
  - Match approach to current mood state and focus on strengths
  - Focus on patient goals for treatment
  - Listen for both positive and negative associations with symptoms and medication side effects; engage with patients’ experience of medications
  - Distinguish bipolar disorder from comorbid conditions
  - Explore ways medication fits with patient story



# Medications for Bipolar Maintenance

- **First-line:** Usually same regimen that successfully treated acute bipolar mood episode
- **Second-line:** If don't tolerate first-line maintenance pharmacotherapy, consider the following (present in general order of preference based on efficacy in reducing suicide risk, # of trials, risk of side effects, cost):
  - Lithium
  - Valproate (divalproex)—third line for women of childbearing age
  - Quetiapine
  - Lamotrigine
- **Third-line:**
  - Aripiprazole (oral or long-acting injectable formulations)
  - Olanzapine
  - Risperidone (oral or long-acting injectable formulations)

# Metabolic Monitoring for Antipsychotic Drugs

Metabolic Indicator	Baseline	4 weeks	8 weeks	12 weeks	Quarterly	Annually	At least every 5 years
Personal or family history	X					X	
Weight/BMI	X	X	X	X	X		
Waist circumference	X			X		X	
BP	X			X		X	
Fasting plasma glucose	X			X		X	
Fasting lipid profile	X	*		X			X

*\*Olanzapine, quetiapine, clozapine*



# Working as a CoCM Team—PCP Approaches

<b>Biological—Evidence-Based Pharmacotherapy</b>	<b>Psychosocial—Evidence-Based Behavioral Treatment</b>
First-line treatment: Mood stabilizer meds	Validate behavioral interventions that augment medication treatment by explaining and encouraging patients to try this type of treatment
Different treatment phases may require different treatments	Assess engagement with and reinforce behavioral treatment during medical visits by asking patients about progress in treatment



# Working as a Team—BHCM Approaches

<b>Biological—Evidence-Based Pharmacotherapy</b>	<b>Psychosocial—Evidence-Based Behavioral Interventions</b>
Medication adherence opportunity to address any potential barriers to engaging in med management	Evidence-based sleep hygiene approaches important target for initial brief behavioral intervention
Support patients through making med changes and troubleshoot adherence challenges	Interventions shown as helpful in bipolar disorder: CBT, family-focused therapy, interpersonal therapy, social rhythm therapy
Help gather collateral information from family and friends when possible to help with treatment planning	Cell intentionally left blank



## Case 2: Presentation

- 35-year-old man presented to primary care “to get thyroid checked out” —gained 20 pounds over previous six months
  - PCP questioning revealed patient has also experienced low energy with associated “heavy sleeping,” depressed mood, anhedonia, guilt, trouble concentrating, distractibility, and intermittent racing thoughts
- PCP completed full examination
  - TSH within normal limits
  - Urine toxicology negative
- Further assessment: Patient was experiencing 2 manic symptoms (distractibility and racing thoughts) in context of depressive episode
  - History “sounded like mania”
  - PCP referred to CoCM



## Case 2: Assessment with BHCM

- Psychiatric hospitalization when 24 for mania
  - Lifetime mood episode chart: one manic, 6 subsequent depressive episodes, possible hypomanic episode in context of alcohol use
  - Mania and depression improved with lithium treatment
- Currently overweight; slightly elevated blood pressure
- Intermittent preoccupations with death, denied intent to active intent
  - BHCM assessed prior SI experiences, suicide attempts, current risk factors
  - Safety planned
- Difficulty controlling worries, preoccupied with uncertainty about future
- Substance use: 10 cigarettes/day and wants to quit, past episodes of binge drinking but none currently



## Case 2: Psychiatric Case Review

- Psych Consultant reviewed results of structured clinical questions and standardized measures
  - Supported diagnosis of bipolar depression
- Recommended trial of quetiapine or lurasidone or return to lithium b/c effective in past
  - Encouraged clinical team to engage the patient in medication choice



## Case 2: Treatment Course

- Patient preferred to restart lithium b/c previously helpful—PCP prescribed
- At follow-up with BHCM: still experiencing significant depressive symptoms
  - BHCM learned patient had misunderstood instructions, was only taking half daily dose (300 mg)
  - Patient serum lithium level: 0.3mEq/L
- BHCM consulted with Psych Consultant
  - PC advised increasing the dose to 600 mg by mouth at bedtime and check serum lithium level one week later
    - Goal level: 0.8-1mEq/L measured 12 hours after the last dose
    - PCP agreed with plan and instructed patient



## Case 2: Completing Episode of Care

- Increased lithium dose over next 6 months
  - → 1200mg/day in divided doses (600mg po twice daily)
  - Goal: serum lithium level = 0.8mEq/L 12 hours after most recent dose
- Patient PHQ-9 score decreased by 50%, manic symptoms resolved
- Patient continued attending appointments with BHCM to identify goals and problem-solving techniques necessary for achieving the goals
  - BHCM also connected patient with community support
  - Completed relapse prevention plan—included clear indicators for patient to check in with PCP/BHCM and maintenance med recommendations
- Patient returned to care as usual with PCP, quarterly visits for med checks and refills

# Questions?

