Bipolar Affective Disorder
Screening, Diagnosis, Intervention and Treatment

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February 1, 2023

Mountain Plains (HHS Region 8)

MHTTC Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

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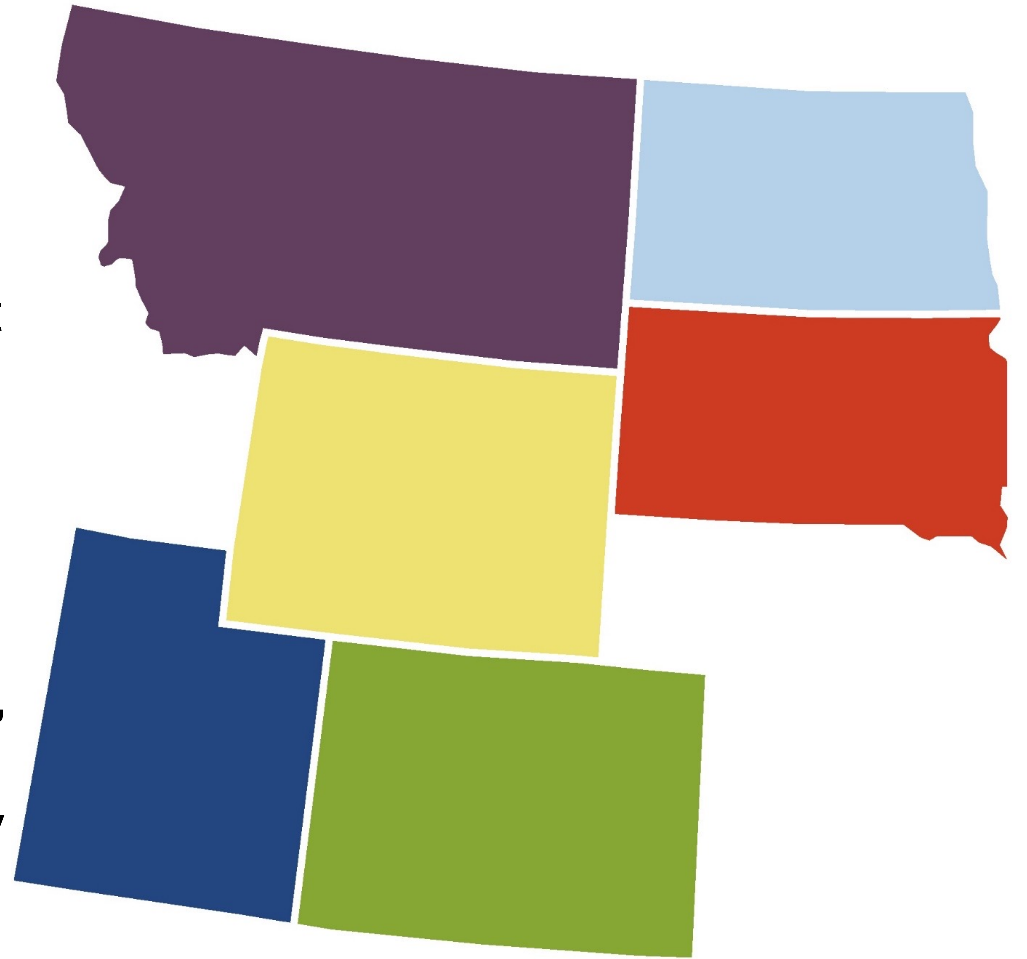
The Mountain Plains Mental Health Technology Transfer Center

The Mountain Plains Mental Health Technology Transfer Center (Mountain Plains MHTTC) provides training and technical assistance to individuals who serve persons with mental health concerns throughout Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming).

We belong to the Technology Transfer Center (TTC) Network, a national network of training and technical assistance centers serving the needs of mental health, substance use and prevention providers. The work of the TTC Network is under a cooperative agreement by the Substance Abuse and Mental Health Service Administration (SAMHSA).



Land Acknowledgement Statement

Today, the University of North Dakota rests on the ancestral lands of the Pembina and Red Lake Bands of Ojibwe and the Dakota Oyate - presently existing as composite parts of the Red Lake, Turtle Mountain, White Earth Bands, and the Dakota Tribes of Minnesota and North Dakota. We acknowledge the people who resided here for generations and recognize that the spirit of the Ojibwe and Oyate people permeates this land. As a university community, we will continue to build upon our relations with the First Nations of the State of North Dakota - the Mandan, Hidatsa, and Arikara Nation, Sisseton-Wahpeton Oyate Nation, Spirit Lake Nation, Standing Rock Sioux Tribe, and Turtle Mountain Band of Chippewa Indians.

The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:

Strengths-based and hopeful

Inclusive and accepting of diverse cultures, genders, perspectives, and experiences

Healing-centered and trauma-responsive

Inviting to individuals participating in their own journeys

Person-first and free of labels

Non-judgmental and avoiding assumptions

Respectful, clear and understandable

Consistent with our actions, policies, and products

Adapted from: https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

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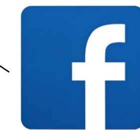

Bipolar Affective Disorder
Screening, Diagnosis, Intervention and Treatment

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Objectives

- After the presentation, the participant will:
- 1) Be able to identify diagnostic criteria for Bipolar Affective Disorder
- 2) Have an understanding of differential diagnoses
- 3) Be able to identify evidence-based treatments of Bipolar Affective Disorder

Summary of DSM-5 Classification of Bipolar Disorders

Bipolar I	Bipolar II	Cyclothymic	Bipolar Disorder Other
One or more manic or mixed episodes, usually accompanied by major depressive episodes	One or more major depressive episodes accompanied by at least one hypomanic episode	At least 2 years of numerous periods of hypomanic and depressive symptoms*	Substance induced, medical, unspecified, other specified…

* Symptoms do not meet criteria for manic and depressive episodes.

Bipolar Affective Disorder

Bipolar I

- Approximately 1% of the population
- F=M

Bipolar II

- Probably twice that of Bipolar I
- F>M

Look at all the Specifiers!

- With anxious distress
- With mixed features
- With rapid cycling
- With melancholic features (note-early morning awakening)
- With atypical features
- With psychotic features
- With catatonia
- With periparum onset
- With seasonal pattern

Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Washington, DC: American Psychiatric Association; 2013.

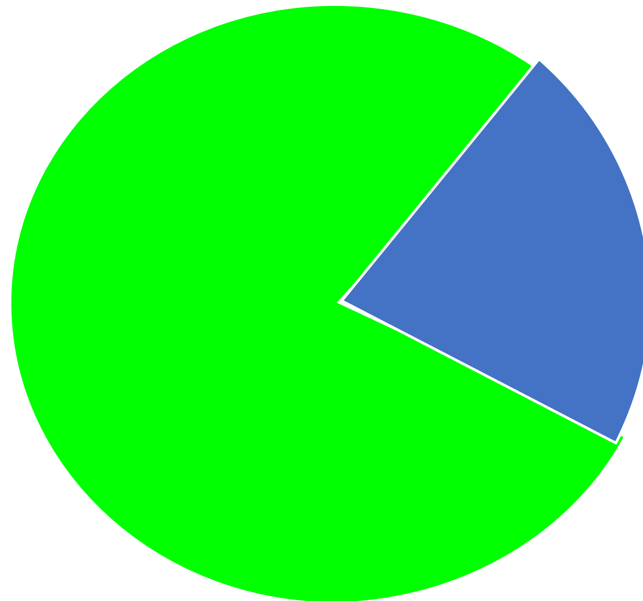
Barriers to Diagnosis

- Quiz:
- Survey: From time of mental health treatment to time of accurate bipolar diagnosis…
- 10 years.

Under-recognition of Bipolar Disorder
Patients Treated for Depression in a Family Medicine Clinic

649 outpatients receiving treatment for depression

Estimated bipolar prevalence among 649 depressed patients ~ 28%



Screened positive* for BD – 21%

MDQ sensitivity = 58%;
MDQ specificity = 93%;
based on Structured Clinical Interview for *DSM-IV* (SCID)

*Using the Mood Disorder Questionnaire (MDQ)

BD = bipolar disorder

Hirschfeld RM, et al. *J Am Board Fam Pract*. 2005;18:233-239.

Summary of DSM-5 Criteria for Manic Episodes in Bipolar Disorder

- Abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy for at least 1 week* with three of the below (four if irritable) present:
  - Inflated self-esteem or grandiosity
  - Decreased need for sleep
  - Pressured speech
  - Flight of ideas or racing thoughts
  - Distractibility
  - Increase in goal-directed activity or psychomotor agitation
  - Excessive involvement in pleasurable activities that have a high potential for painful consequences

Social/Occupational impairment; Symptoms not due to substance/medical condition

* This symptom must be present.

Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Washington, DC: American Psychiatric Association; 2013.

Hypomania

- Mood and energy changes as per “mania,” but for at least four days (vs. 1 week)

  - Other major difference vs. mania:

    The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization.
    (If there is psychosis, it would then fall under “mania…”)

So, for criteria apart from mania:

less number of days symptomatic, and less severe

Mixed Features

- “Dysphoric Hypomania”
- Often misdiagnosed as agitated depression, anxiety, histrionic personality
- Insomnia
- Suicidality
- Impulsivity

- Different from “Rapid Cycling” which is actually 4 or more episodes per year

Major Depressive Disorder—Diagnostic Criteria

Five or more of the following symptoms are present most of the day, nearly every day, during a period of at least 2 consecutive weeks:

At least 1 of these 2 symptoms

1. Depressed mood
2. Loss of interest or pleasure in all, or almost all, usual activities (anhedonia)

3. Significant weight loss when not dieting, or weight gain
4. Insomnia or hypersomnia
5. Psychomotor agitation or retardation
6. Fatigue or loss of energy
7. Feelings of worthlessness or excessive or inappropriate guilt
8. Diminished ability to think or concentrate or indecisiveness
9. Recurrent thoughts of death or suicide

DSM-5.

Symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning and are not attributable to another substance or medical condition

Bipolar Depression *

- **Clues:**

  Might*:
- be more “atypical” (think hibernation)
- have history of early, often abrupt onset/psychosis
- be associated with other cyclical problems (seasonal…)
- be associated with post-partum
- have family history
- have history of “overstimulation” with antidepressants.
- Migraines?

Suicide

- Of all affective states, Bipolar II has the highest risk for attempts and suicide completion.

- RE: phases of illness and suicide risk,

Depressive>Mixed>Psychotic>Manic[1]

1 Bowden CL. Novel Pharmacologic Interventions in the Treatment of Bipolar Disorder. *Academy for Healthcare Education CME Monograph. 2002*

- Remember,
  “Screening, Diagnosis, Intervention and Treatment?”

- Screening is just that-not an assessment
- An assessment is necessary for diagnosis
- Screening and diagnostic tools are aids.

Diagnostic Tools

- “No Substitute for Good Clinical Skills”
- Longitudinal information
- Collateral information

Differential Diagnosis (What else could this be?)

- Medical conditions
- (thyroid disease, anemia, sleep disorders, infections, autoimmune diseases, etc…)
- Other psychiatric disorders
- Medication side effects
- Bereavement
- Psychosocial stressors/adjustment
- Substance use
- Other

COMORBIDITY IS THE RULE!

Mood Disorder Questionnaire

- Comprises 13 yes/no symptom questions,
  1 co-occurrence question, and 1 functional impairment question

- MDQ positive cases:

7 or more symptoms AND co-occurrence during same time period AND moderate to severe functional impairment

- Positive screens indicate the need for a full clinical evaluation

Mood Disorder Questionnaire

Patient Name ______________________ Date of Visit ______________

Please answer each question to the best of your ability

1. Has there ever been a period of time when you were not your usual self and...	YES	NO
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found that you didn't really miss it?	☐	☐
...you were more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family in trouble?	☐	☐
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐

3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?

☐ No problems ☐ Minor problem ☐ Moderate problem ☐ Serious problem

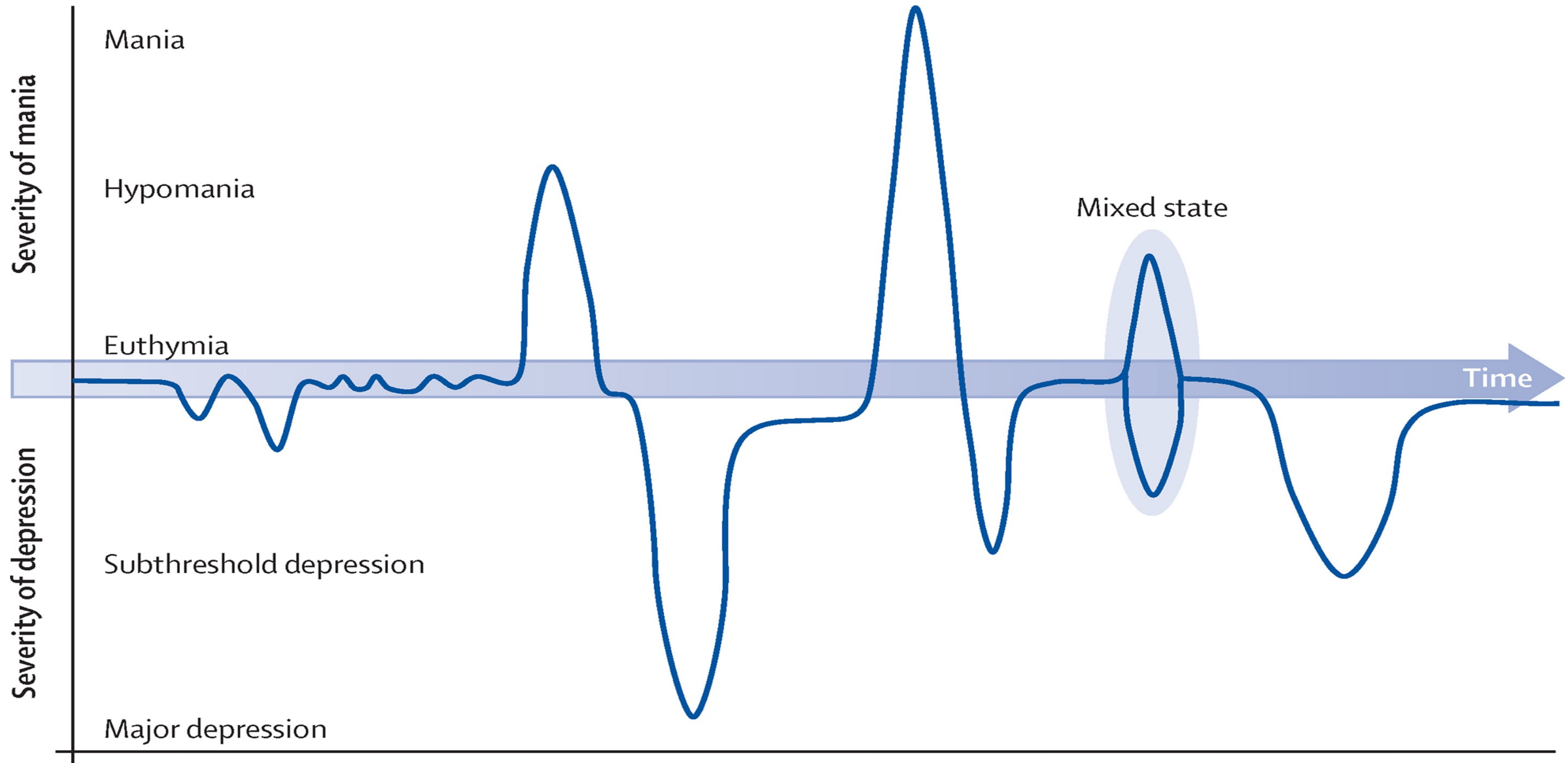
Designed for screening only, not diagnosis. RMA Hirschfield, MD

Young Mania Rating Scale

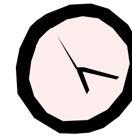
Questions pertaining to the following elements:

1) Elevated Mood
2) Increased Motor Activity/Energy
3) Sexual Interest
4) Sleep
5) Irritability
6) Speech
7) Language/Thought Disorder
8) Content
9) Disruptive-Aggressive Behavior
10) Insight

Interventions and Treatment



Psychotherapy



Particular Therapies:

- CBT- Cognitive Behavioral Therapy
- IPSRT- Interpersonal and Social Rhythm Therapy
- Family-Focused Therapy

Children and Adolescents

- A major differential diagnosis:
- Symptoms greater than 12 months.

Disruptive Mood Dysregulation disorder (DMDD)

DMDD symptoms usually begin before the age of 10. A child with DMDD experiences:

An irritable or angry mood most of the day, almost every day.

Severe temper outbursts (verbal or behavioral) that are out of proportion to the situation. These usually happen three or more times per week.

Issues with daily functioning due to irritability in more than one environment, such as at home, at school or with their peers.

Cleveland Clinic

Medications

- Generally, for Bipolar Affective Disorder, the primary group of medications that are recommended are the “mood stabilizers.”

- These typically included lithium, certain anticonvulsant medications, certain antipsychotic medications, rarely antidepressant medications*

Partial List of FDA Approved Medications in Bipolar Affective Disorder Phases

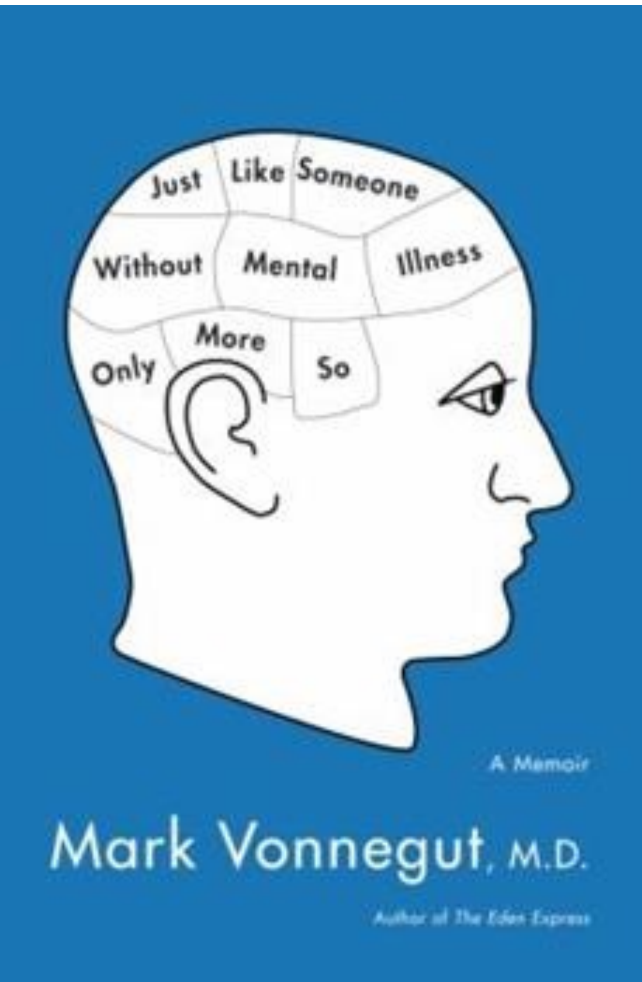
Generic Name	Trade Name	Mania	Mixed	Maintenance	Depression
Valproate	Depakote	X			
Carbamazepine Ext. release	Equetro	X	X		
Lamotrigine	Lamictal			X	*
Lithium		X		X	*
Aripiprazole	Abilify	X	X	X	X (TRD)
Ziprasidone	Geodon	X	X		
Risperidone	Risperdal	X	X		
Quetiapine	Seroquel	X			X, plus TRD
Chlorpromazine	Thorazine	X			
Olanzapine	Zyprexa	X	X	X	
Olanzapine/Fluoxetine comb.	Symbyax				X, plus TRD
Lurasidone	Latuda				X
Cariprazine	Vraylar	X	X		*

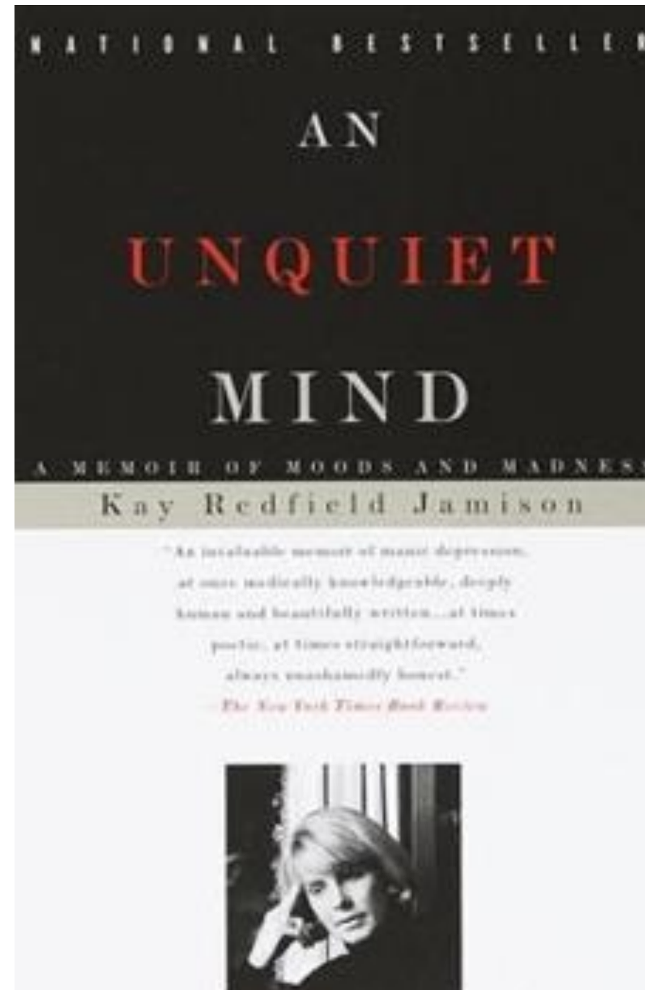
Neuromodulation

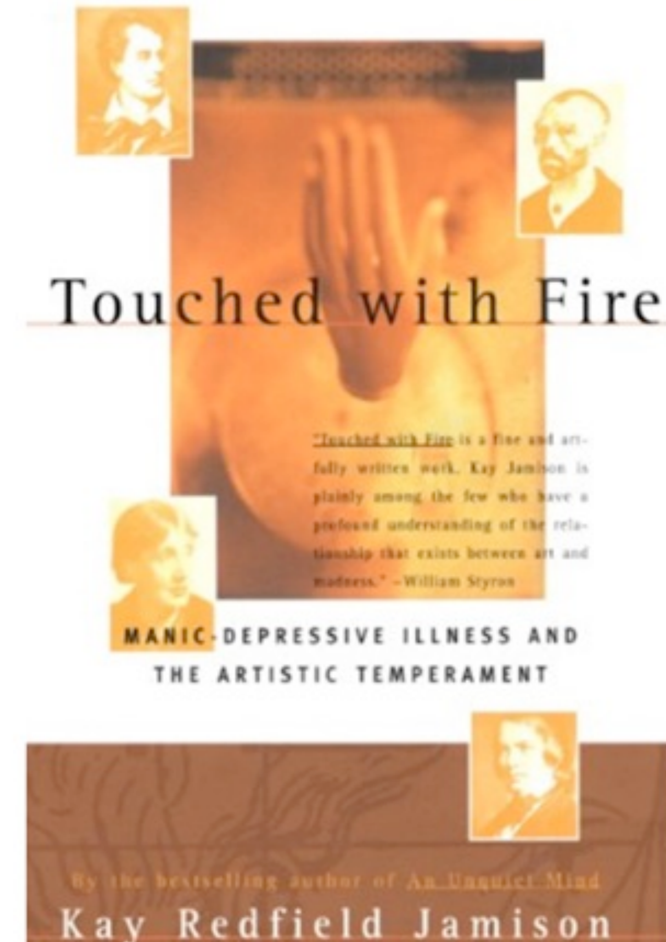
- ECT
- TMS
- Light Therapy

Resources

For your “leisure” reading







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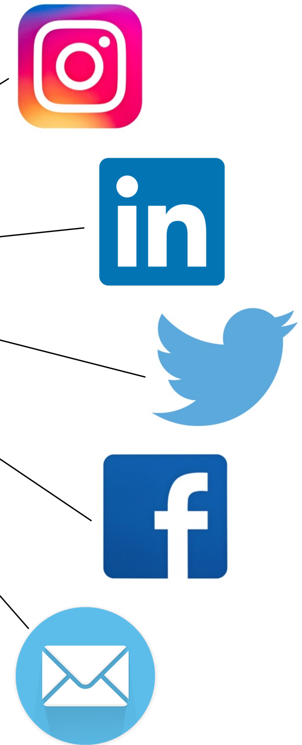

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