FRAMEWORKS
in Health and Quality

Understanding and Diagnosing Bipolar Disorder

Treatment for Bipolar Disorder

A Resource for Providers

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Greater than 33% of patients with bipolar disorder remained misdiagnosed for ten or more years, delaying treatment.[5]

Treatment for Bipolar Disorder

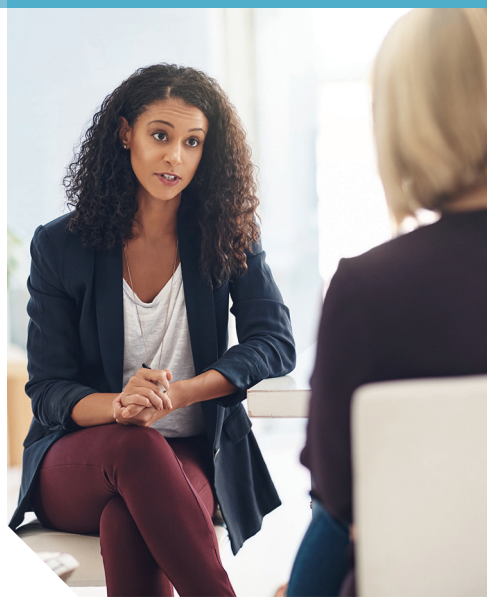
Importance of Treatment for Bipolar Disorder

Bipolar disorder is a chronic mental illness and refers to a spectrum that encompasses several diagnoses, including bipolar I, bipolar II, and cyclothymic disorder.[1,2]

Bipolar I disorder, marked by extreme manic episodes, has a **lifetime prevalence of 2.1%** and a **12-month prevalence of 1.5%**.[2,3] This equates to approximately **4.9 million** and **3.7 million** adult Americans, respectively, who are affected.[3] The onset of bipolar disorder typically begins **between the ages of 15-24**.[4] There is often a considerable interval between onset and first treatment or first hospitalization.[4]

In a constituency survey by the National Depressive and Manic-Depressive Association, one in four individuals with bipolar disorder reported receiving an accurate diagnosis within three years of first experiencing symptoms. Moreover, greater than 33% of patients remained misdiagnosed for ten or more years. The lapse between the onset of symptoms and an accurate diagnosis of bipolar disorder can delay treatment.[5]

While there is no cure for bipolar disorder, treatment can decrease related morbidity and mortality. In addition to medication therapy, individuals may benefit from the addition of psychosocial interventions that address illness management and interpersonal difficulties. These psychosocial interventions are designed to address adherence to treatment, illness adaptation, self-esteem, and management of relationships.[4]



Approaching Treatment of Bipolar Disorder

According to the American Psychiatric Association, the general goals of treatment are to manage acute episodes, prevent recurrences, improve inter-episode functioning, and provide support to the patient. The treatment of bipolar disorder is comprised of two main phases—acute and maintenance—each with different goals. Patients enter the maintenance phase after successful completion of the acute phase.[4]

Treatment Goals[4]

Acute Phase	Maintenance Phase

• Stabilization
• Achieve remission
  - Complete return to baseline level of functioning
  - Virtual lack of symptoms
	• Optimize protection against recurrent episodes
	• Maximize patient functioning
	• Minimize subthreshold symptoms
	• Minimize adverse effects of treatment

Patients frequently seek treatment when they are experiencing an acute episode, which may be characterized by depression, mania, hypomania, or a mixture of features.[4]

Primary care providers may encounter bipolar disorder, as it is common in primary care settings.[6] A collaborative care approach with communication between providers, such as the primary care provider and the psychiatrist, may be needed. A patient-centered team approach may offer the greatest likelihood of success.[7]

Treatment for Individuals With Bipolar Disorder

Considerations in the Treatment of Bipolar Disorder

Patients with bipolar disorder, including bipolar I, may face challenges which contribute to low treatment rates.[3]

Some considerations for providers include:

Comorbidities: Patients with bipolar disorder are predisposed to have other psychiatric disorders. Comorbid conditions are associated with longer episodes of illness, shorter periods of remission, poor treatment compliance, and suicidality.[8]

Adverse side effects: Patients with bipolar disorder may experience unwanted side effects from medications, or combination of medications.[3,7]

Finances: Patients with bipolar disorder may lack insurance or face other financial barriers.[3,4]

Poor insight: Patients with bipolar disorder may lack insight, which may interfere with their ability to make treatment decisions.[3,4]

Stigma: Frequently cited as a barrier to mental healthcare, stigma is associated with reduced treatment seeking.[9]

Additional considerations in the general treatment of bipolar disorder include:

Stress: Psychosocial stress is a known trigger to both manic and depressive symptoms.[6]

Suicidality: Suicide is more frequent among patients with bipolar disorder than it is among patients with other psychiatric or general medical disorders.[8] Associations between bipolar I disorder and anxiety and substance use disorders have been linked to greater likelihood of suicide attempts and deaths.[3]

Support: Patients who have social support in recognizing early warning signs of relapse appear to have a lower likelihood of recurrence and hospitalization and have improved functioning.[6] Additionally, family may be able to assist in providing an informative history, given the patient's potential lack of insight.[4,7]

Education: Patients and families may have difficulty accepting the fact that bipolar disorder is an illness that will require long-term treatment. Ongoing patient education can help reinforce the patient's collaborative role in treatment.[4]

Treating Bipolar Disorder

According to a constituency survey by the National Depressive and Manic-Depressive Association, greater than 33% of patients with bipolar disorder reported remaining misdiagnosed for ten or more years, and such a lapse between the onset of symptoms and an accurate diagnosis of bipolar disorder can delay treatment.[5] Additionally, while estimates vary across the literature, the average bipolar medication nonadherence rate is reported to be 40%. Nonadherence is associated with outcomes such as relapse, hospitalization, functional impairment, and suicidality.[10]

In conjunction with medication, psychosocial interventions, which focus on illness management tactics, may offer some benefit to patients with bipolar disorder.[7]

Psychosocial interventions

Psychosocial interventions which may be considered for patients with bipolar disorder include:

- Psychoeducation[7]
- Cognitive behavioral therapy[4,7]
- Family-focused therapy[7]
- Interpersonal and social rhythm therapy[4,7]
- Group psychotherapy[4]
- Peer support[11]

Psychosocial therapies may help with regularizing daily activities, medication adherence, and recognizing early warning signs of relapse.[6]

Treatment for Individuals With Bipolar Disorder

Use of Medications

Several treatment guidelines offer direction for how to treat bipolar disorder. These guidelines can help providers determine options for a patient, based on clinical assessment and individual patient circumstances.

Evidence-based medication treatment guidelines:

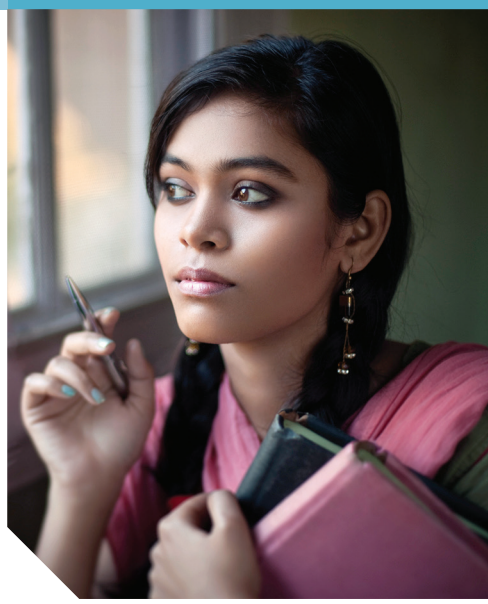
- *The American Psychiatric Association Practice Guideline for the Treatment of Patients with Bipolar Disorder* offers treatment recommendations based on available evidence and clinical consensus.[4]
- The Texas Medication Algorithm Project describes guidelines for appropriate care based on research and clinical consensus when adequate research is lacking.[12]

Federal Drug Administration approval includes indications for medications that have passed scientific reviews for specific uses in specific disorders.[13,14]

Medications that have been used to treat bipolar disorder include:

- Mood stabilizers[15]
- Antidepressants[16]
- Antipsychotics[16]

Ongoing medication is considered the foundation for successful treatment of bipolar disorder.[17]



Monitoring Treatment

Monitoring response is important for all treatments. For patients with bipolar disorder, who may lack insight, especially during manic episodes, monitoring is particularly important. Small changes in behavior may indicate the onset of an episode.[4]

Some information that may help in monitoring treatment includes:

- Typical sequence of a patient's illness[4]
- Typical duration of an acute episode[4]
- Typical severity of an acute episode[4]
- Depressive, manic, and sleep symptoms[6]

Additional monitoring considerations may include:

Screening for medical morbidities: There is a high frequency of medical comorbidities in patients with bipolar disorder.[7]

Education: For patients, regarding how they are able to monitor their own symptoms for potential relapse is important. Patient and family education can improve decision making and collaboration with the healthcare team.[7]

Medication regimen: Patients may find side effects burdensome, and medication regimen complexity may contribute to nonadherence.[4,10]

Suicidality: Among the phases of bipolar disorder, depression is associated with the highest risk.[8] Patients and families need a plan for addressing suicidal ideation, should it become evident, which is something providers are able to assist with developing.[6]

References: 1. Bipolar disorder. National Alliance On Mental Illness web site. https://www.nami.org/Learn-More/Mental-Health-Conditions/Bipolar-Disorder. Updated 2017. Accessed July 6, 2017. **2.** American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. Arlington, VA: American Psychiatric Publishing, 2013. **3.** Blanco C, Compton WM, Saha TD, et al. Epidemiology of DSM-5 bipolar I disorder: Results from the National Epidemiologic Survey on Alcohol and Related Conditions–III. *Journal of Psychiatric Research*. 2017;(84)310-317. **4.** Hirschfeld R, Bowden CL, Gitlin MJ, et al. *Practice Guideline for the Treatment of Patients With Bipolar Disorder*, 2nd ed. Arlington, VA: American Psychiatric Publishing; 2002. **5.** Living with Bipolar disorder: how far have we really come? National Depressive and Manic-Depressive Association. http://www.dbsalliance.org/pdfs/bphowfar1.pdf. Published 2001. Accessed June 21, 2017. **6.** Price AL, Marzani-Nissen GR. Bipolar disorder: A review. *American Family Physicians*. 2012;85(5):483-493. **7.** Culpepper L. The diagnosis and treatment of bipolar disorder: Decision-making in primary care. *Primary Care Companion CNS Disorders*. 2014;(16)3. **8.** Jann MW. Diagnosis and treatment of bipolar disorder in adults: A review of the evidence on pharmacologic treatments. *American Health & Drug Benefits*. 2014;7(9):489-499. **9.** Dockery L, Jeffery D, Schauman O, et al. The stigma- and non-stigma related treatment barriers. *Psychiatry Research*. 2015;228:612-619. **10.** Gaudiano BA, Weinstock LM, Miller IW. Improving treatment adherence in bipolar disorder: a review of current psychosocial treatment. *Behav Modif*. 208;32(3):267–301. **11.** Peer support research. National Depressive and Manic-Depressive Association. http://www.dbsalliance.org/site/PageServer?pagename=wellness_peer_support_research. Accessed June 24, 2017. **12.** Crimson ML, Argo T, Bendele S, et al. Texas Medication Algorithm Project: Procedural Manual. Texas Department of State Health Services. https://www.jpshealthnet.org/sites/default/files/tmap_bipolar_2007.pdf. Published 2007. Accessed June 30, 2017. **13.** How drugs are developed and approved. U.S. Food & Drug Administration. http://www.fda.gov/Drugs/DevelopmentApprovalProcess/HowDrugsareDevelopedandApproved/. Updated August 18, 2015. Accessed May 15, 2017. **14.** FDA Approved Drugs for Psychiatry/Psychology. https://www.centerwatch.com/drug-information/fda-approved-drigs/therapeutic-area/17/psychiatry-psychology. Published 2016. Accessed May 20, 2017. **15.** Ketter TA. Mood stabilizers and second-generation antipsychotics: Pharmacology, drug interactions, adverse effects, and dosing. In Ketter, TA, ed. *Advances in Treatment of Bipolar Disorders*. Arlington, VA: American Psychiatric Publishing, Inc. 2005;24(3)1-9. **16.** Geddes JR, Miklowitz DJ. Treatment of bipolar disorder. *Lancet*. 2013;381(9878):1672-1682. **17.** Connolly K, Thase M. The Clinical Management of Bipolar Disorder: A Review of Evidence-Based Guidelines. *The Primary Care Companion for CNS Disorders*. 2011;13(4).

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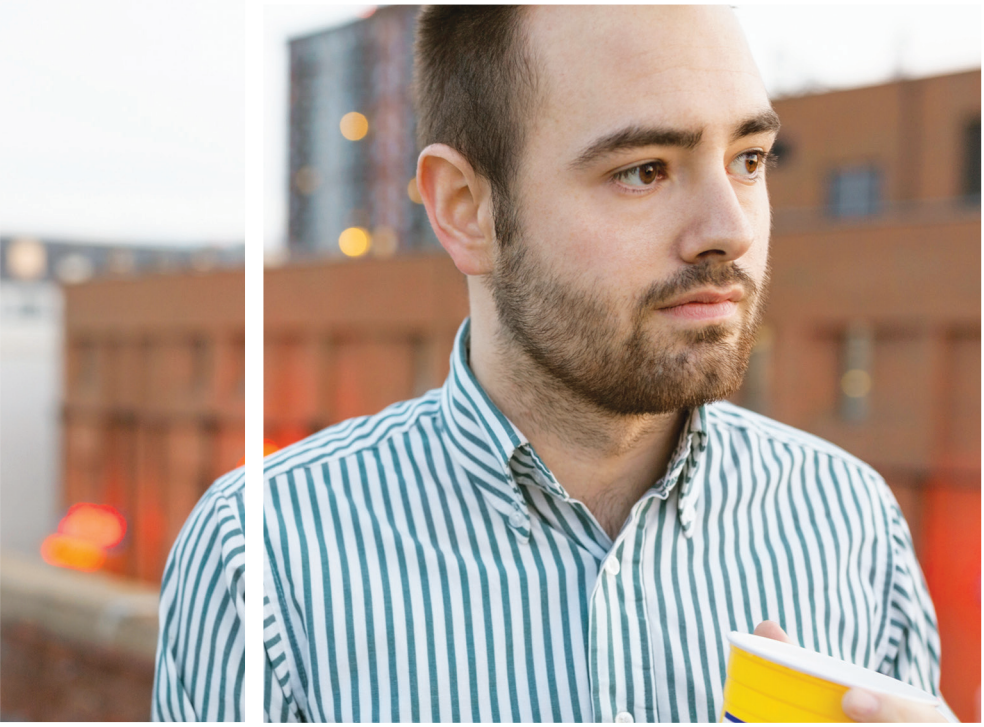

Combating Stigma for Patients With Bipolar Disorder

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Combating Stigma for Patients With Bipolar Disorder

The onset of bipolar disorder typically begins **between the ages of 15-24**. There is often a considerable interval between onset and first treatment or first hospitalization.[7]

The Role of Stigma in Care

Patients with mental illness, such as those who have bipolar disorder, can experience stigma that may negatively impact their care.[1] While working to manage the symptoms of their disease, patients who experience stigma are also faced with combating stereotypes and misconceptions associated with their illness.[1] Unfortunately, the healthcare system is one of the key environments in which patients with mental illness may experience stigma and discrimination.[2]

Bipolar I, marked by extreme manic episodes, has a **lifetime prevalence of 2.1%** and a **12-month prevalence of 1.5%**.[3,4] This equates to approximately **4.9 million** and **3.7 million** adult Americans, respectively, who are affected.[4]

Patients with bipolar disorder may feel stigmatized for their disorder. Although there are not many studies which focus specifically on stigma and patients with bipolar disorder, there is substantial research related to stigma and mental illnesses.[5] This resource is based upon this knowledge and belief that patients with bipolar disorder may be subject to the same types of stigma as those patients with other mental illnesses.

This resource aims to assist providers in understanding the types of stigma, consequences of stigma, strategies to combat stigma, and collaborating with the patient in light of stigma.

The Importance of Combating Stigma

Stigma has been identified as one of the primary barriers to accessing care and to receiving equitable quality of care.[2] It is frequently cited as a barrier to mental healthcare and is associated with reduced treatment seeking.[6]

For people with mental illness, stigma can lead to[2]:

- Greater internalization of stigmatizing beliefs and self-silence
- Inadequate access to proper treatment
- Less treatment compliance
- Breakdown of the therapeutic relationship
- Greater avoidance of healthcare services

Combating Stigma as a Provider

One of the most promising strategies for combating stigma seems to be contact with a patient with mental illness characterized by equal status, cooperation, common goals, and support by authorities. However, despite having this contact, the healthcare system is still an environment where providers may manifest stigmatizing attitudes and behaviors. Healthcare providers typically see patients with mental illness when they are most unwell, which may give providers a biased view of the patient and his or her chance of recovery. Moreover, some providers may feel uncomfortable with their abilities to assess certain patients with mental illness and then communicate effectively with those patients about their care.[2]

Strategies that providers can employ include:

Enhance communication with patients, as well as between providers.[2]

Engage in skill-based training to learn what to do to help; for example, the "what to do to help" approach which has been used as part of some anti-stigma programs.[2]

Be sensitive to your internalized beliefs about individuals with mental illness. Focus on the individual and not just the disease and do not endorse stereotypes about people with mental illness.[8]

Portray people realistically. Patients with bipolar disorder experience periods without symptoms. Avoid depicting the illness and the patient's symptomology as always being in an acute episode, and instead, describe their entire life and the cycles of their condition.[9]

Ask other professionals and leaders to help combat stigma. More voices leads to more awareness.[8]

Tell your own story. If you happen to have a story of recovery, share it.[8]

Additionally, as a provider, you are in a unique position to help individuals with mental illness find their voice to speak out about mental illness and discrimination. The credibility you have as a professional in the mental health field can go a long way in promoting individual storytelling in public.[8]

The Substance Abuse and Mental Health Services Administration offers a guide for developing a local, regional, or statewide initiative to combat stigma.[10]

Collaborating With the Patient

One of the results of stigma is the societal belief that patients with mental illness should be feared and, therefore, excluded and may be seen as needing to be cared for and incapable of making their own decisions.[1]

Avoid labels

Encourage patients to recognize that they are more than their illness and, therefore, a "patient with bipolar," not "I am bipolar."[11]

Choose your words thoughtfully

Many negative terms associated with mental health conditions ("crazy," "psycho") have become part of the common vernacular but can cause someone to feel stigmatized.[9]

Emphasize supports

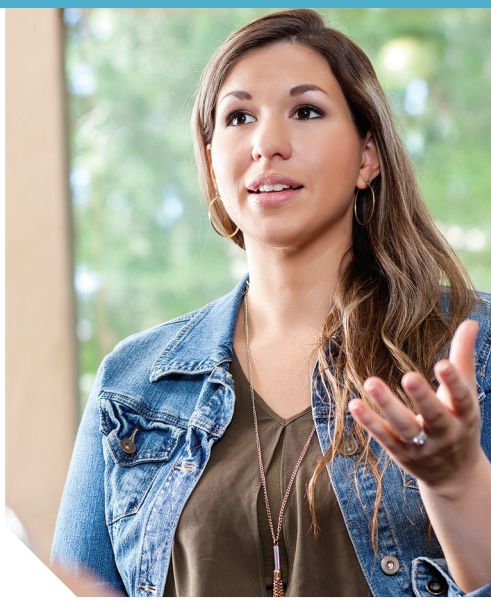
As stigma may result in reduced access of care, encourage patients to seek support groups and not to isolate themselves. Speaking with others who have bipolar disorder may help patients to better understand and gain greater control over their illness. Patients engaged in peer support programs have been shown to be more likely to use behavioral health services of all kinds.[12] Groups such as the National Alliance on Mental Illness and the Depression and Bipolar Support Alliance offer local and Internet supports.[13,14]

Underscore autonomy

Stigma contributes to the belief that patients with mental illness are unable to make their own decisions.[1] This may be especially present when a patient is acutely ill. Providers can encourage autonomy by offering a psychiatric advanced directive, which outlines a patient's wishes when they are unable to do so himself or herself.[15]

Encourage appropriate self-disclosure

Self-disclosure of mental illness has been shown to result in positive outcomes related to help-seeking and feelings of inclusion.[12] When clinically indicated and justified, and when the patient believes it will help, it may be beneficial for individuals to disclose their illness to loved ones, friends, and coworkers.



In addition to combating stigma as a provider, **there is the opportunity to collaborate with the patients** so that they are empowered in their care.

Understanding Stigma

Stigma falls into four categories

Public stigma is based on the endorsement of a stereotype of mental illness by the general population. For example, the idea that a patient with mental illness is dangerous or unreliable may result in a landlord not offering housing to them.[8]

Self-stigma is the result of the patient internalizing the discriminatory beliefs and then acting based on the internal belief. For example, if a patient believes a stereotype which suggests that people with mental illness are unreliable, they may believe that they are unable to keep up with the demands of a job because of their mental illness.[8]

Label avoidance refers to a third type of stigma, which prevents patients from seeking care. In an attempt to avoid being labeled, patients may not seek behavioral health services.[8]

Structural stigma refers to societal norms and institutional practices which may limit the opportunities and resources available to a stigmatized patient.[16] For example, in various government jurisdictions, individuals with serious mental illness have been discriminated against by regulations limiting their voting rights, their ability to hold public office, parental custody, housing, and employment.[12] This type of stigma may also be visible in a lack of integrated care services, or a lack of appropriate referrals to behavioral health providers.[17]

As a provider, it is important to recognize that a patient may be experiencing different types of stigma and that the stigma may be impacting care.

Stigma
can be considered a multifacted concept
involving labelling, negative stereotyping, separation of “them” from “us,” status loss, and discrimination.[6]

References: 1. Corrigan P, Watson A. Understanding the impact of stigma on people with mental illness. *World Psychiatry*. 2002;(1):16-20. **2.** Ungar T, Knaak S, Szeto, AC. Theoretical and practical considerations for combating mental illness stigma in health care. *Community Ment Health J*. 2016;(52):262-271. **3.** American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders,* 5th ed. Arlington, VA: American Psychiatric Publishing; 2013. **4.** Blanco C, Compton WM, Saha TD, et al. Epidemiology of DSM-5 bipolar I disorder: results from the National Epidemiologic Survey on Alcohol and Related Conditions – III. *J Psychiatry Res*. 2017;(84):310-317. **5.** Griffiths KM, Carron-Arthur B, Parsons A, et al. Effectiveness of programs for reducing the stigma associated with mental disorders. A meta-analysis of randomized controlled trials. *World Psychiatry*, 2014;(13):161-175. **6.** Dockery L, Jeffery D, Schauman O, et al. The stigma- and non-stigma related treatment barriers. *Psychiatry Res*. 2015;228:612-619. **7.** Hirschfeld R, Bowden CL, Gitlin MJ, et al. *Practice Guideline for the Treatment of Patients With Bipolar Disorder*, 2nd ed. Arlington, VA: American Psychiatric Association Publishing; 2002. **8.** Corrigan P. Lessons learned from unintended consequences about erasing the stigma of mental illness. *World Psychiatry*. 2016;(15):67-73. **9.** 10 ways to combat discrimination with compassionate language. Depression and Bipolar Support Alliance web site. http://www.dbsalliance.org/site/PageServer?pagename=dbsa_language. Accessed June 22, 2017. **10.** Substance Abuse and Mental Health Services Administration. Developing a stigma reduction initiative. https://store.samhsa.gov/product/Developing-a-Stigma-Reduction-Initiative-with-CD-/SMA06-4176. Published 2006. Accessed June 21, 2017. **11.** Mental health: overcoming the stigma of mental illness. Mayo Clinic web site. http://www.mayoclinic.org/diseases-conditions/mental-illness/in-depth/mental-health/art-20046477. Published May 24, 2017. Accessed June 22, 2017. **12.** National Academies of Sciences, Engineering, and Medicine. *Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change*. Washington, DC: National Academies Press; 2016. **13.** Find your local NAMI. National Alliance on Mental Illness web site. https://www.nami.org/Find-Your-Local-NAMI. Accessed June 21, 2017. **14.** Peer support research. Depression and Bipolar Support Alliance web site.http://www.dbsalliance.org/site/PageServer?pagename=wellness_peer_support_research. Accessed June 24, 2017. **15.** Scheyett A. Psychiatric Advanced Directives: Empowering Consumers With Serious Mental Illnesses. National Association of Social Workers web site. http://www.helpstartshere.org/health-and-wellness/disabilities/disabilities-your-options-psychiatric-advance-directives-empowering-consumers-with-serious-mental-illnesses.html. Accessed June 21, 2017. **16.** Corrigan P, Druss B, Perkick D. The impact of mental illness stigma on seeking and participating in mental health care. *Psychol Sci Public Interest*. 2014;15(2):37-70. **17.** Pugh T, Hatzenbuehler M, Link B; for Committee on the Science of Changing Behavioral Health Social Norms. Structural stigma and mental illness. http://sites.nationalacademies.org/cs/groups/dbassesite/documents/webpage/dbasse_170045.pdf. Published August 2015. Accessed June 30, 2017.

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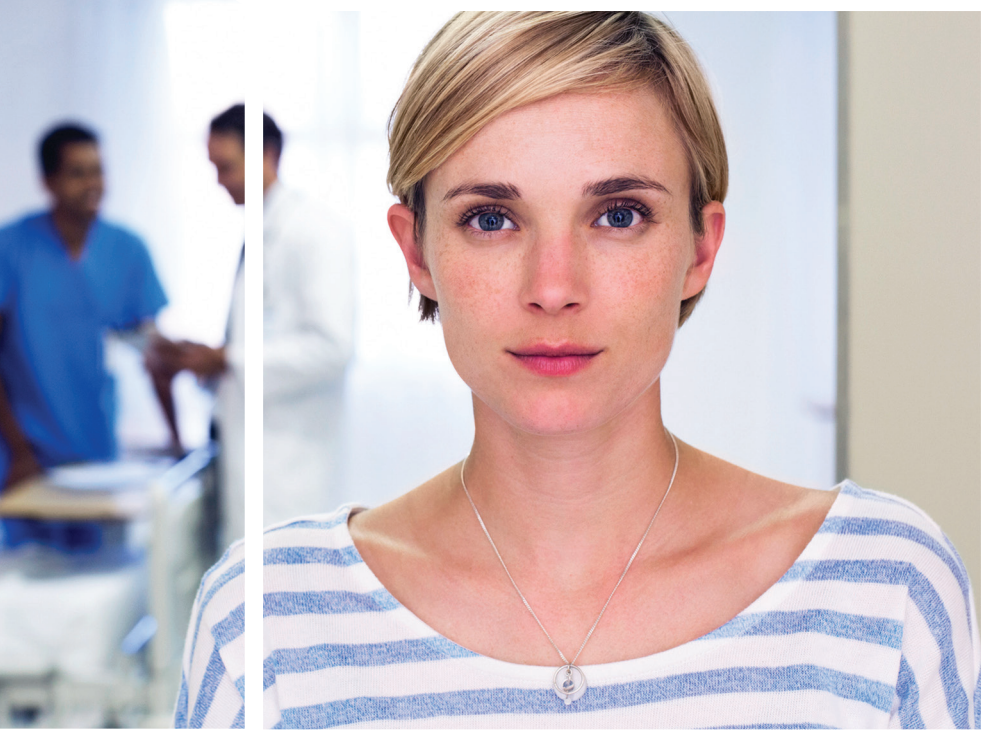

Evidence-Based Diagnostic Criteria for Bipolar Disorder

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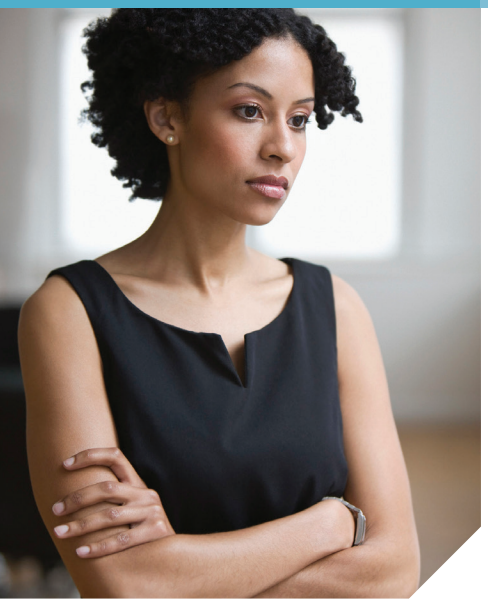
Evidence-Based Diagnostic Criteria for Bipolar Disorder



The onset of bipolar disorder typically begins **between the ages of 15-24**. There is often a considerable interval between onset and first treatment or first hospitalization.[7]

Bipolar Disorder Is a Spectrum

Bipolar disorder is a chronic mental illness and refers to a spectrum that encompasses several diagnoses, including bipolar I, bipolar II, and cyclothymic disorder.[1,2] Disorders on this spectrum are common, affecting about 2.8% of the United States population.[3] Conditions on this spectrum involve significant and sometimes dramatic shifts in mood, energy, and activity levels.[4]

Bipolar I disorder, marked by the occurrence of a manic episode, has a lifetime prevalence of 2.1% and a 12-month prevalence of 1.5%.[2,5] Although a history of at least one depressive episode is not necessary to receive this diagnosis, the majority of patients who meet criteria for a manic episode will experience a depressive episode at some point in their lifetime.[2]

Bipolar II disorder, defined by a history of one or more depressive episodes and at least one hypomanic episode, has a lifetime prevalence of 1.1% and a 12-month prevalence of 0.8%.[2,3] Although patients with bipolar II disorder experience hypomania rather than mania, this disorder is not considered "milder" than bipolar I disorder, due to the time these patients spend in depressive episodes and the impairments in social and occupational functioning that occur as a result of mood instability.[2]

Cyclothymic disorder is diagnosed when an adult experiences at least two years of depressive and hypomanic symptoms that do not at any point meet criteria for an episode of major depression, mania, or hypomania.[2]

Misdiagnosis and Comorbidities

In a constituency survey by the National Depressive and Manic-Depressive Association, only one in four patients with bipolar disorder reported receiving an accurate diagnosis within three years of first experiencing symptoms. Moreover, greater than 33% of these patients remained misdiagnosed for ten or more years.[6]

Negative consequences may not be limited to mental health; patients with untreated bipolar disorder have higher rates of death from cardiovascular causes.[8]

Why do misdiagnoses happen?

Unipolar depression is more common than bipolar depression, and patients with bipolar disorder are more likely to present with depression.[9] Patients may also experience a series of depressive episodes before ever experiencing a manic, hypomanic, or mixed episode.[8,10]

The symptoms of depression for a patient with bipolar disorder may be similar to the symptoms of depression for a patient without bipolar disorder. This may potentially lead to a misdiagnosis.[4]

Patients with bipolar disorder may have symptoms which prompt providers to consider diagnoses such as attention-deficit/hyperactivity disorder, personality disorders, panic disorders, substance use disorders, or schizophrenia spectrum disorders.[2]

Comorbidities

There are several conditions which are frequently comorbid with bipolar I disorder, including panic disorder, agoraphobia, and post-traumatic stress disorder, as well as borderline, schizotypal, and antisocial personality disorders.[5]

Substance use disorder is a common comorbidity for men and women with bipolar disorder.[6] Co-occurring substance use and anxiety disorders may place the patient at higher risk for suicide.[5]

Medically, patients with bipolar disorder have a high rate of comorbidities, including diabetes, cardiovascular disease, hepatitis C virus infection, obesity, and migraine.[11] Patients with bipolar disorder may be at an elevated risk of not following preventative health measures.[12]

Without an accurate diagnosis, a patient with bipolar disorder may receive treatment that is inadequate or ineffective.[9]

Evidence-Based Diagnostic Criteria for Bipolar Disorder

Patients with bipolar disorder are more likely to present with depression.[8,9]

Mania and Hypomania

For a diagnosis of bipolar I disorder, it is necessary to meet the following criteria for a manic episode. The manic episode may have been preceded by and may be followed by hypomanic or major depressive episodes.[2]

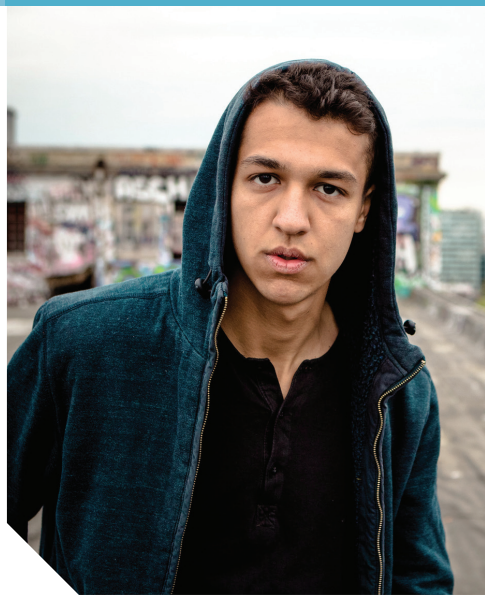
The criteria for a manic episode includes a period of mood disturbance lasting at least a week and causing marked social or occupational impairment or requiring hospitalization to prevent harm to self or others. During this disturbance, the patient exhibits abnormally and persistently elevated, expansive, or irritable mood and abnormally or persistently increased activity or energy, including at least three of the following symptoms[2]:

- Inflated self-esteem or grandiosity
- Decreased need for sleep
- Pressured speech
- Racing thoughts
- Distractibility
- Increase in goal-directed activity
- Psychomotor agitation
- Excessive involvement in high-risk activities

The criteria for a hypomanic episode includes symptoms identical to those in a manic episode, which may persist for a shorter period of time (at least four days). Although such symptoms must represent a change from the patient's usual behavior, they do not cause marked impairment or require the person to be hospitalized.[2]

Depression

Patients with bipolar disorder are more likely to present with depression.[8,9] The vast majority of individuals whose symptoms meet the criteria for a manic episode also experience major depressive episodes during the course of their lives. While common in bipolar I disorder, major depressive episodes are not required for the diagnosis of bipolar I disorder.[2]



The criteria for a major depressive episode must include one of the following[2]:

- A depressed mood
- Markedly diminished interest or pleasure in almost all activities

These symptoms must occur for most of the day, nearly every day, over the course of at least a two-week period, and must be accompanied by at least four other symptoms among the following[2]:

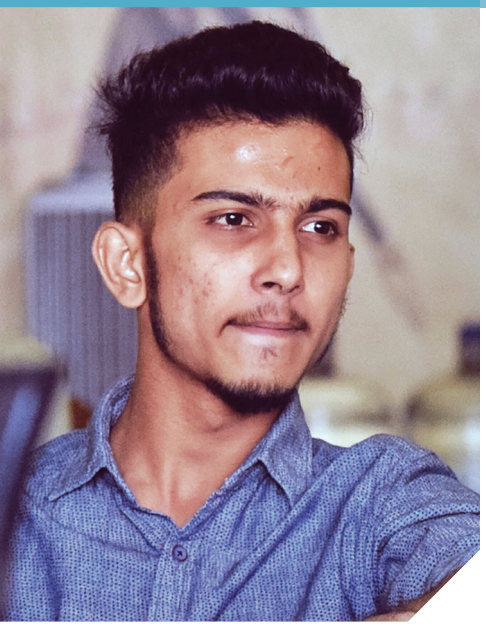
- Significant weight loss or gain or decreased or increased appetite
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness or excessive or inappropriate guilt
- Diminished ability to think or concentrate
- Recurrent thoughts of death or suicidal ideation

Making a diagnosis of bipolar I or II disorder may involve identifying such patients from among those presenting with symptoms of unipolar depression.[9]

Information a provider may wish to consider includes[9]:

- Family history of bipolar disorder
- Age at onset of illness or symptoms
- Treatment history for depression, including experiences with medication
- History of past hospitalizations and suicide attempts
- Number of past episodes, including mania, hypomania, or mixed episodes
- History of symptoms, including psychosis, cognitive impairment, and mood reactivity

Evidence-Based Diagnostic Criteria for Bipolar Disorder



Evidence-Based Screening

Evidence-based screening tools, which include questions regarding the symptoms of bipolar disorder and may point to the need for further assessment, include:

- **Mood Disorder Questionnaire (MDQ):** A 15-question validated self-reporting tool. Patients answer questions regarding symptoms, symptom clusters, and functional impairment. When used, the MDQ can help identify almost three-quarters of individuals with bipolar disorder and screen out the diagnosis in 90% of those who do not have it.[9] It is available through the Substance Abuse and Mental Health Services Administration (SAMHSA).[13]

- **Standards for Bipolar Excellence (STABLE):** A resource toolkit published by SAMHSA. It includes screening tools, assessments, and best practice information for monitoring bipolar disorder.[14]

- **Hypomania/Mania Symptom Checklist (HCL-32):** A 32-question validated self-reporting tool. It has questions on emotional state, usual mood/activity/energy, and symptoms. When used, the HCL-32 can help identify 80% of individuals with bipolar disorder and screen out the diagnosis in 51% of those who do not have it.[9]

Early diagnosis may reduce the risk of relapse and improve response to treatment.[8]

Strategies for Providers

With the knowledge that bipolar disorder is a mental illness, providers may be able to employ the following strategies, which have been recommended for mental illnesses in order to support diagnosis.

Combat stigma

Stigma has been identified as one of the primary barriers to access care.[15] It is frequently cited as a barrier to mental healthcare and is associated with reduced treatment seeking.[16] Bipolar disorder is common in primary care settings.[8] Reducing discrimination in these settings may help the chances of effective screening and early intervention for mental health conditions.[17]

Collaborate and co-locate

A collaborative care model may identify gaps in care and improve the care team's ability to brainstorm solutions. Historically, primary care providers are the ones who make the diagnosis and initially treat patients with mental health issues. Collaboration and co-location may also contribute to early intervention, by way of a culture shift in how providers practice. Co-location of psychiatric and primary care services may increase each provider's knowledge of the other's standards and promote functional integration.[17]

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