

## RECOGNIZING BIPOLAR DISORDER IN PRIMARY CARE

Interview with J. Sloan Manning, MD

*J. Sloan Manning, MD, is a family practice physician who had spent 12 years in academic medicine before recently returning to private practice. He is codirector of the Mood Disorders Clinic at the Moses Cone Family Practice Residency, Moses Cone Hospital in Greensboro, North Carolina, and holds an adjunct associate professor appointment at the University of North Carolina.*

*Dr Manning has long held an interest in affective disorders, stemming in part from his own family experience and observation, during his residency training and clinical practice, of the high proportion of family practice patients who were depressed and/or anxious.*

*A senior clinical editor for Johns Hopkins Advanced Studies in Medicine (JHASiM) interviewed Dr Manning to discuss diagnosing bipolar disorder in primary care.*

**JHASiM: What is the biggest challenge in diagnosing a bipolar disorder in primary care?**

*Dr Manning:* The biggest challenge for primary care is still awareness of the issue. Most of us in primary care learned about diagnosing and treating depression in the early 1990s. The literature showing that bipolar disorder is a prevalent disorder and a spectrum of mood disorders came out after primary care clinicians began to use antidepressants widely. We've been putting the "cart before horse" during the past 15 years in that we've jumped to treatment of depression without considering differential diagnosis first.

I frequently say "all that's depressed is not major depression." The criteria for a major depression and a bipolar depression are the same (except for, of course, the history of a manic or hypomanic episode with bipolar disorder). Thus, clinicians often don't know to look for a bipolar disorder or even what it looks like. We are not thinking in terms of differential diagnosis.

We're jumping to treatment before we've had a chance to accurately diagnose.

**JHASiM: Most people think of a manic episode as a euphoric state, an expansive, elevated mood. However, it can also present similarly to highly agitated depression. What has been your experience with the presentation of mania/hypomania?**

*Dr Manning:* Certainly, full-blown mania is not hard to diagnose. However, it's not something that presents very commonly in primary care; I see it once or twice a year in my practice. However, there is this assumption—and it's a wrong assumption—that "manic" is something you'd like to be, that the manic patient is happy and excessively productive. Most people don't realize that mania is very uncomfortable, destructive, and unpleasant for most patients. Suppes et al showed recently that even hypomania is not a pleasant experience, particularly for women.<sup>1</sup> It's most often irritable, restless, driven energy; it is not experienced as elated. Patients may appear to be or act elated but they can also have significant depression at the same time, which is a mixed episode. I was taught in medical school that you were manic or depressed, but the reality is the 2 states very often coexist or overlap, and it always makes the depression more dangerous to have that manic energy.

**JHASiM: How do you determine a history of mania/hypomania?**

*Dr Manning:* The Mood Disorders Questionnaire (MDQ) is a very reasonable, first-order screening tool, in which the patient actually gets to read about, identify, and endorse manic symptoms. Everyone in my practice who is anxious, depressed, or has some sort of psychopathology gets this screening tool. The MDQ does not make a diagnosis; it's a way of starting a conversation about symptoms we may not have talked about. However, you can't just accept a negative result

as evidence of a nonbipolar illness. Patients with bipolar disorder may lack insight into their manic symptoms or may not want to admit they experience such periods—or maybe their symptoms aren't covered well by this tool. We also use a temperament profile (TEMPS-A), which detects cyclothymia. Our research shows that this tool accurately identifies patients with bipolar disorder II.

Longitudinal studies indicate that bipolar patients tend to be temperamentally mood labile. People with bipolar disorder II often identify with the statements, "My mood has always shifted abruptly, for no particular reason. I never know what mood I'm going to be in." If you look at bipolar disorder II and other types of bipolar disorder, most of the shifting is to depressed mood. When these patients complain about being "depressed most of the time," but offer, "I felt 'fine' or 'normal' for 3 to 4 days last week," the clinician then needs to ask, "What did 'fine' look like? How long did you feel normal? What did you do?" What you find in many of those patients is that their "normal" is not really normal: they're having brief hypomanic episodes, which last 2 or 3 days, perhaps more. The patients may describe that energy and activity as their normal state, when it really isn't, because they have a decreased need for sleep with racing thoughts. Perhaps they're spending too much money and going too far sexually or rearranging furniture and cleaning their homes until the early morning hours. Therefore, it doesn't look exactly normal but they feel "normal" because it beats being depressed. The energy is adaptive. The mood is often predominantly irritable, particularly in women, but active and irritable trumps, in most people, depressed and hypersomnic. However, it's not normal to feel normal only 2 or 3 days every month, especially when "normal" appears and disappears suddenly.

I also see cases in which everything, including the family history, looks like a typical major depression. However, when the patient is started on an antidepressant, he or she says, "The antidepressant made me hyper and racy or made me feel angry or more depressed." In these cases, I tell the patient we need to review their history because that reaction can suggest treatment-emergent mania or mixed states.

It's not absolutely essential to get information from the spouse or significant other, but it is very important and enlightening and always better than not having it. This can be true especially if there is a family history

of bipolar disorder. For some patients, the last thing they want to be linked to is a mentally ill relative, thus they won't tell the doctor anything that may arouse suspicion that the patient has a relative with mental illness. Some people deceive because they are embarrassed and some people just don't have insight. Some people are so grandiose during the manic episode that they won't recognize their own manic behaviors (eg, "No, you don't understand. When I lost my job, it was because my supervisor didn't realize what a key person I was.")

**JHASM: Can you describe a typical first presentation of a patient with bipolar disorder in primary care?**

*Dr Manning:* The first presentation is virtually always depression. How do you know it's bipolar? You have to ask! And, you have to know what to look for. It's not necessarily going to take 45 minutes to diagnose. It may, but we all have patients with hypertension and diabetes in our practice with whom we're going to spend 20 or 30 minutes doing monofilament screening for peripheral neuropathy, discussing cardiovascular risk, interpreting an X ray or EKG (electrocardiogram), and reviewing laboratory results. What's the difference between committing 20 minutes to a patient with diabetes and 20 minutes to a patient with mood disorder? It's really all about your motivation.

I ask basic questions, such as "How old were you when you had your first major depression or depressive episode?" If the first depression or a suicide attempt was in the early teen years, the illness is usually not unipolar depression, which doesn't show up until the age of 25 or 30 years. Therefore, in approximately 5 or 10 minutes, an experienced clinician can ask a few key questions and have the patient fill out an MDQ. I'll usually ask the patient to complete the instruments, give them some information on mood disorders, and return 15 minutes later to ask them what they think. I also ask about family history. If there is a first-order relative with bipolar disorder, the patient is much more likely to have a bipolar disorder than unipolar depression.

Therefore, a preliminary diagnosis doesn't take as long as one might imagine. Physicians tell me, "I don't have 60 minutes." Well, I don't either. But you do have 15 minutes times 4. Therefore, you can get part of the history and do some laboratory work (including a thyroid profile and metabolic testing) and bring the patient back in a few days for another evaluation. You

can also send them home with some information to read. At the next visit, ask “What kind of symptoms did you identify with? Do you have some of them? If so, let’s talk about them.”

It can be done in primary care, at the same level of involvement as dealing with the patient with asthma, diabetes, or hypertension. It’s not like treating a sore throat. Physicians who don’t care to invest the time and effort to learn are never going to be interested, but that’s not most primary care physicians (PCPs). Most PCPs are simply unaware of the importance of bipolar disorder and, if they were aware, most would say, “I can learn to do this.”

**JHASiM: How often is substance abuse involved?**

*Dr Manning:* A lot—not necessarily in the first presentation, but a life history of substance abuse is there at least 50% of the time. When it is coexisting with the bipolar disorder, you need to address both problems at the same time. You don’t ask someone to get sober and then deal with their mood disorder. I tell everyone that a train runs on 2 tracks. If we only treat the mood disorder and let the substance abuse run amok, the mood is not going to be okay. On the other hand, if we attend only to the substance abuse issue, there will be mood aberrations that will challenge and probably derail the patient’s efforts to stay clean and sober. The challenge is that to treat that comprehensively, patients need 12-step treatments or referral to a psychotherapist, who may not be able to see them right away. Therefore, the patient may lose interest or the opportunity may pass for some other reason. I’d much rather have a psychotherapist in my practice who can be contacted immediately and warmly introduced to the patient, but that is for a future version of primary care.

**JHASiM: How do you convince your patients to see a psychiatrist if you suspect or have diagnosed bipolar disorder?**

*Dr Manning:* If someone presents with suicidal or homicidal ideation, I insist that they see a psychiatrist or be evaluated in a psychiatric hospital immediately. If they refuse and I know there is suicidal or homicidal intent, I swear out a warrant for their arrest and involuntary commitment. That has happened to me only once in the past 2 years, but I will contact a judge to start the commitment process. If it’s not that severe, but I know the patient’s illness or situation is beyond the scope of my practice, I tell the patient “I can’t take care of you in my

practice. I’m going to refer you.” You’re also trying to elicit the support of friends or family members. If I have a good working relationship with the patient and permission to do so, I would call the spouse. In some of these cases, a family member is regularly coming into the examination with the patient, thus I have implicit permission to contact the family member. In other cases, I don’t have permission to do that and I have had occasion to decline talking with a patient’s spouse because he or she wasn’t part of the spouse’s treatment. In those cases, you talk to the patient and say, “You have to get more help. We need to involve others.” There will be situations in which patients expressly state that they don’t want family members, friends, or any support person involved. That’s sad, particularly for people with bipolar disorder, because involving supportive people in their circle is optimal for a good outcome.

It’s also important to maintain sensitivity but make honest statements, and if a patient is offended by frankness, it still doesn’t stop me from sharing important information.

**JHASiM: What is your relationship to the psychiatrist in the long-term management of a patient with a bipolar disorder?**

*Dr Manning:* That’s the sad part. For patients who are not actively suicidal, and aren’t candidates for the hospital it can be weeks to months before they can see the psychiatrist. I do have a few relationships with psychiatrists and psychologists who can squeeze in a patient at my request.

We’ve built 2 separate healthcare systems that don’t talk well to each other—medical care and mental health. My dream would be to have a psychiatrist right down the hall from me. That’s where we need to go in healthcare delivery because if you’re not mentally healthy, you’re not likely to be healthy in any other way. And yet, we separate mental health and regular healthcare services, thus the PCP is limited in what he or she can do.

For the patient, seeing a psychiatrist is a completely different experience from that of primary care. Some patients won’t go because, in their own thinking, they aren’t that sick, it takes a long time to get an appointment, they sense the negative stigma, or their insurance won’t cover it or to the same extent that their other healthcare is covered.

We have to change the whole way we deliver mental healthcare in this country to address the problem.

Insurance companies don't have a vested interest in making sure these services are available, but the reality is that human beings are complicated creatures needing healthcare that integrates these crucial aspects of assessment and treatment.

**JHASiM: What should PCPs know about the neurobiology of bipolar disorder?**

*Dr Manning:* The neurobiology of bipolar illness is not completely worked out. I prefer to describe bipolar disorders in terms of systems in the brain that control mood. I'm trying to get away from saying there's too much or too little dopamine/serotonin/norepinephrine. It's overly simplistic and flat out wrong for most situations. We don't know enough about the neurobiology of bipolar disorders to tell people what the precise problem is. We were sold the story in the 1990s that depressed people have too little serotonin and SSRI (serotonin selective reuptake inhibitor) antidepressants work because they raise serotonin levels. It's much more complicated.

I prefer to broaden the discussion by saying that 1 or more of the control systems of mood do not function properly and we don't know the common denominator. There may be 2, 3, or 5 types of bipolar disorder, based on which parts of the system are broken. We do know that the drugs we use to treat bipolar disorders, in randomized controlled trials, are effective for specific symptoms or symptoms of the illness. You can also talk about increased metabolic activity in certain brain areas during manic episodes or reduced activity during depressions; we have evidence of that.

REFERENCE

1. Suppes T, Mintz J, EcElroy SL, et al. Mixed hypomania in 908 patients with bipolar disorder evaluated prospectively in the Stanley Foundation Bipolar Treatment Network: a sex-specific phenomenon. *Arch Gen Psychiatry*. 2005;62:1089-1096.