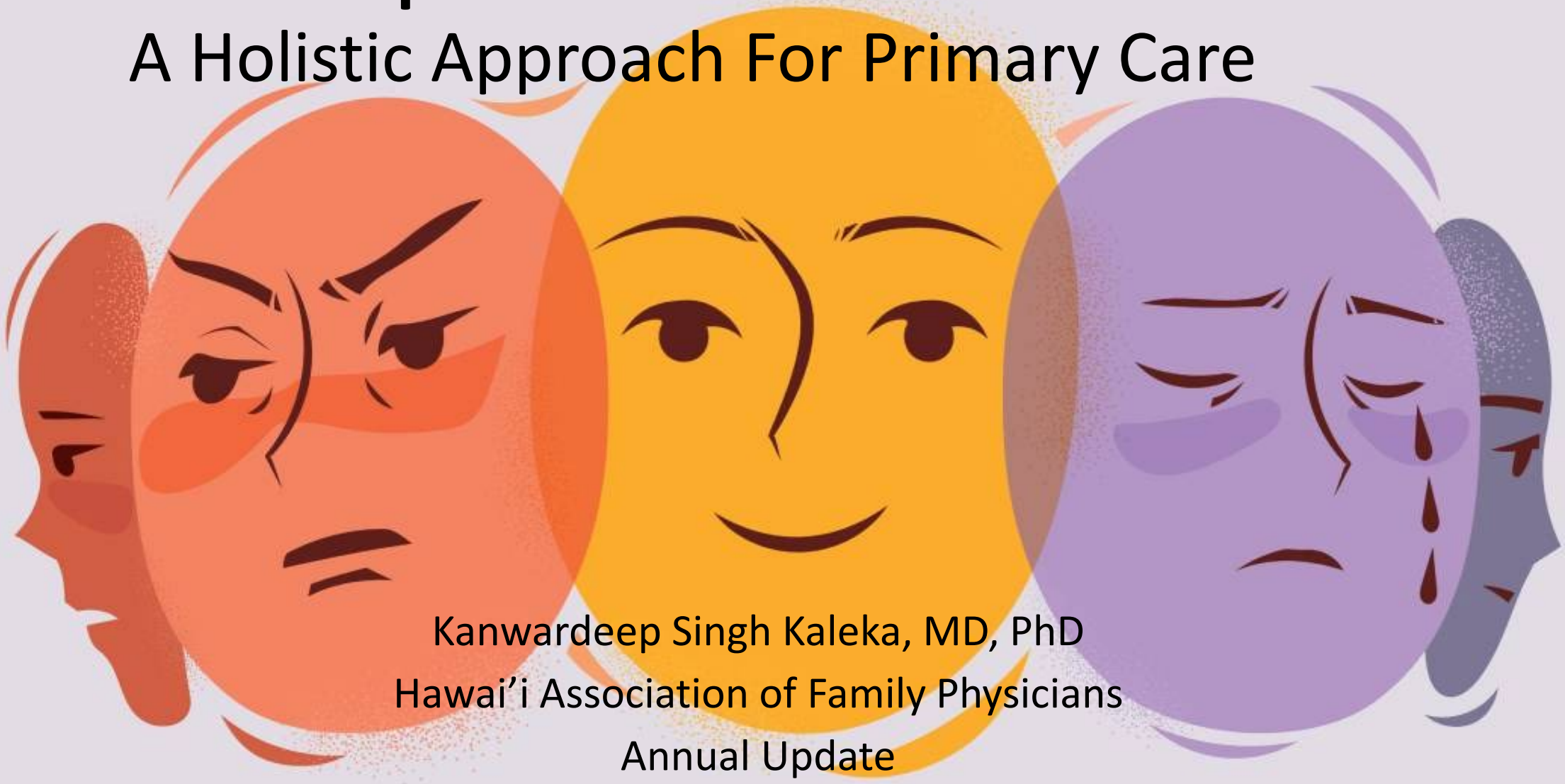
Bipolar Disorder:

A Holistic Approach For Primary Care



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Annual Update

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Disclosures

- One financial disclosure: I received a small stipend for travel to be here
- This presentation is simply my perspective based on a combination of clinical experience and evidence I've looked at over the years.
- Overall purpose is to provide a peak behind the curtain of a psychiatrist who also practices primary care.
- This presentation is catered to a broad audience including those who practice in a setting with limited psychiatric resources.
- There is no expectation for you to retain this information unless you have that expectation, but rather a smorgasbord of food for thought.

Brief Overview

- How bipolar disorder can present in primary care
- Types of mood disorders
- What can underlie symptoms?
- What can we do about it?
  - Deeper Healing
  - Lifestyle
  - Medications
- Questions/Discussion

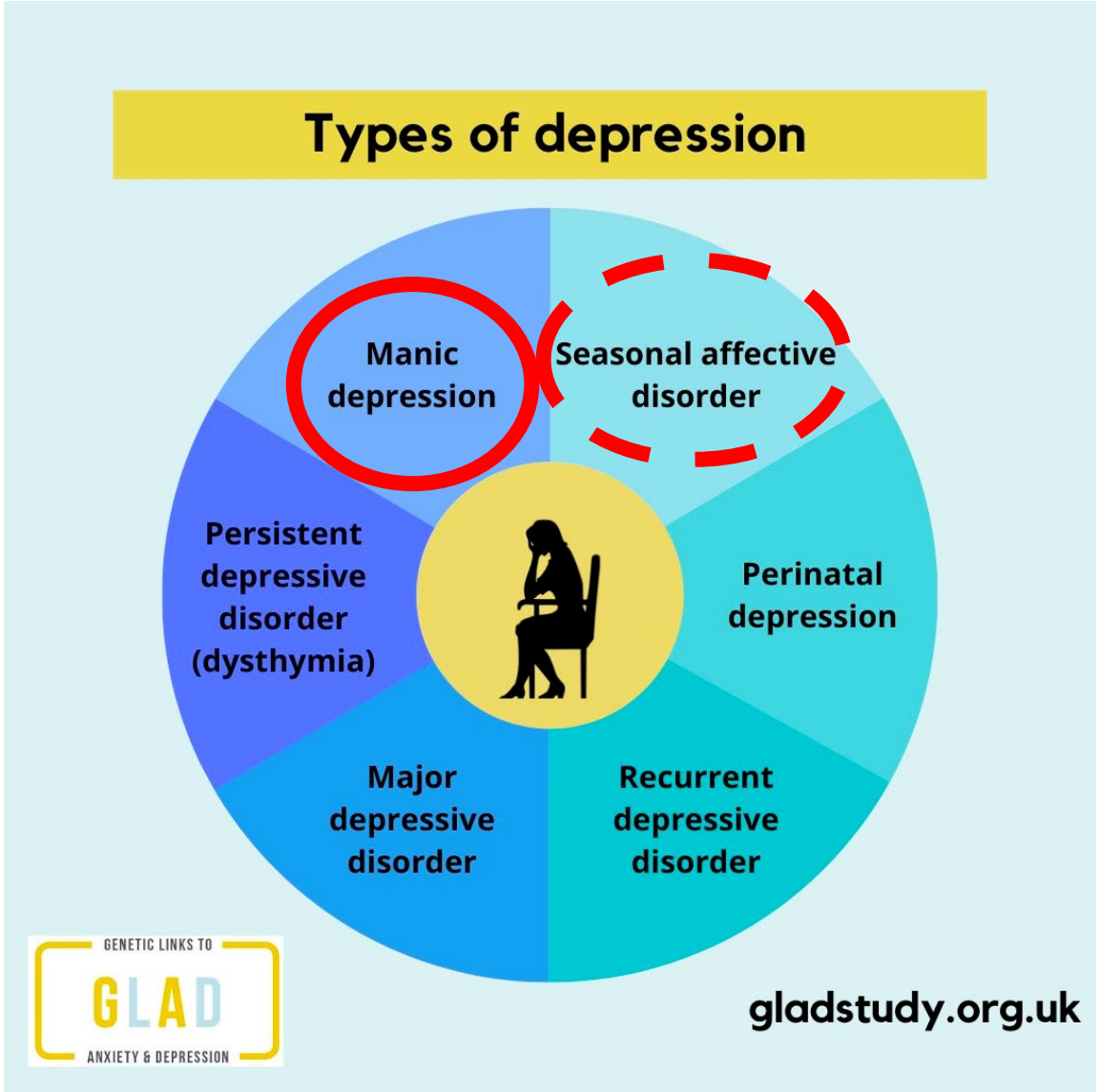
Bipolar Disorder Presentation in Primary Care

- Depression is the most common presentation
  - SIG E CAPS: Sleep, Interest, Guilt, Energy, Concentration, Appetite, Psychomotor, **Suicidality/Hopelessness**
  - Irritability, Social isolation/Withdrawal, Memory Problems
  - Physical symptoms – Headaches, digestive problems/abdominal pain, low sex drive, MSK pain (particularly back pain), frequent infections
  - Medication non-compliance, worsening chronic disease (DM and HTN)
  - Increased substance use (alcohol, cannabis, stimulants)
    - Chicken or Egg? Or Both?
  - Differential: Endocrine (Hypothyroidism, Adrenal insufficiency), Vitamin (D, B**2**, 3, 5, 6, **9, 12**) and Iron deficiency, Dementia, Cancer, Infection/Illness (HIV, Syphilis and EBV)

Bipolar Disorder Presentation in Primary Care

- Mania or hypomania (more rare)
  - DIG FAST: Distractibility, Irresponsibility/Irritability, Grandiosity, Flight of Ideas/Racing Thoughts, Activity increased, Sleep Decreased, Talkative
  - Psychotic symptoms: delusions (paranoid, religious, grandiose), auditory hallucinations
  - Differential:
    - Hyperthyroidism
    - Vit B12 deficiency
    - Substances
      - Stimulants (meth, cocaine, PCP, nicotine, caffeine), Steroids, Hallucinogens
      - UDS
    - Delirium
    - Other mental health disorders: ADHD, Personality disorders, OCD, MDD w/ psychosis

Types of Depressive Disorders



Seasonal Affective Disorder

- Depressive symptoms develop or worsen during fall and winter months.
- The prevalence of SAD varies with geographical latitude, age and sex.
  - The prevalence increases at higher latitudes with SAD being more common in people living far from the equator where there are fewer daylight hours in the winter.
  - Younger people and women are also at higher risk.
- In addition to usual treatment for depression, use of “Happy Light” is beneficial, sometimes as monotherapy.

Seasonal Affective Disorder

- Happy Light Instructions
  - 10K Lumen light easily found online, Walmart, Target, etc.
  - Standard protocol
    - Keep light elevated above eye level (preferable)
    - About 30 min first thing in the morning
    - Use daily to maximum benefit
    - Ask what patient’s usual morning routine is to figure out ideal location
    - Can do this year round or stop in Spring and Summer

DSM-V Criteria for Bipolar Disorder

Elevated, expansive, or irritable mood must last for at least one week and be present most of the day, nearly every day. To be considered hypomania, the mood **must last at least four consecutive days** and be present most of the day, almost every day.

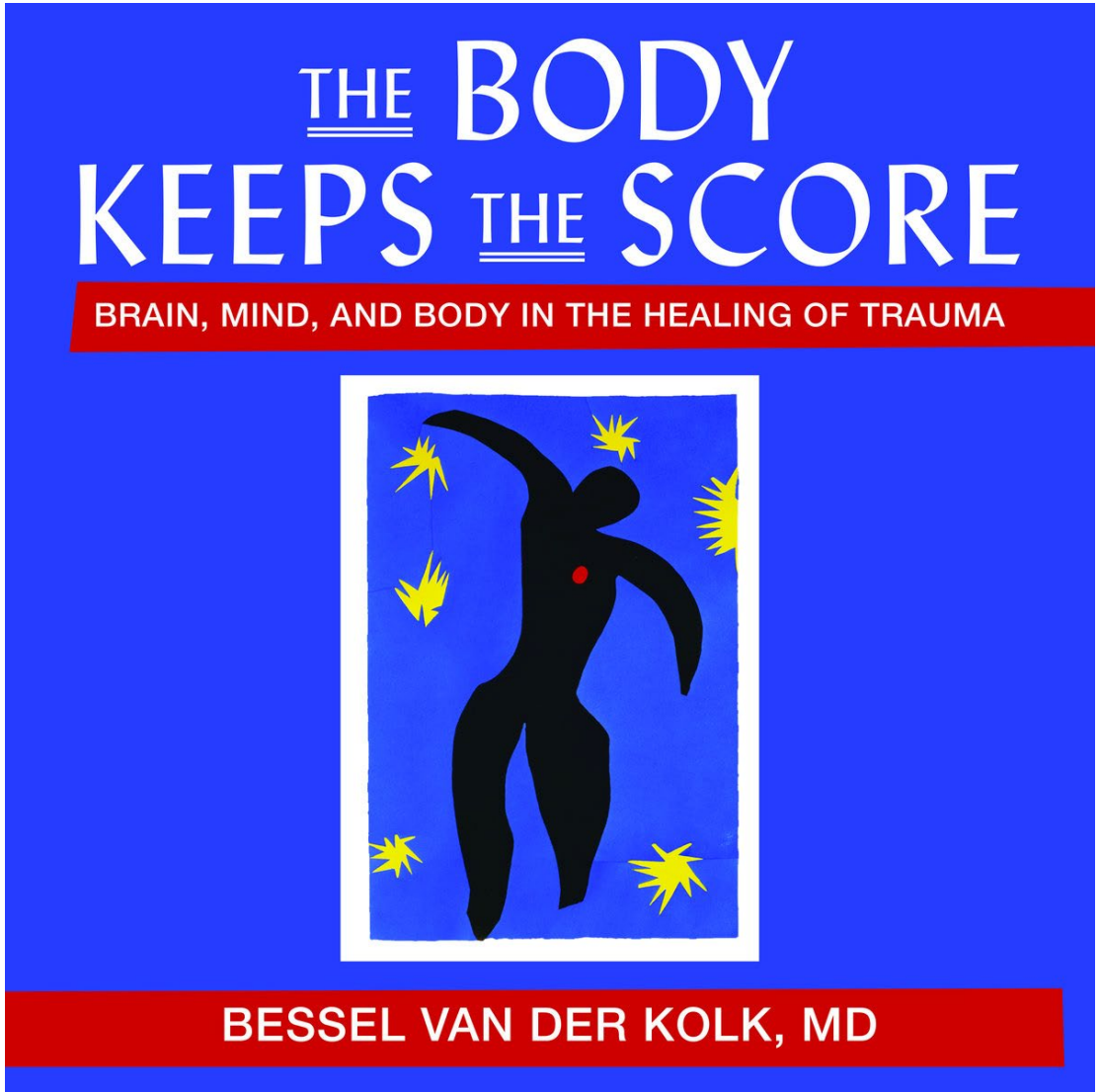
During this period, three or more of the following symptoms must be present and represent a significant change from usual behavior:

- Inflated self-esteem or grandiosity
- **Decreased need for sleep**
- Increased talkativeness
- Racing thoughts
- Distracted easily
- Increase in goal-directed activity or psychomotor agitation
- Engaging in activities that hold the potential for painful consequences, e.g., unrestrained buying sprees

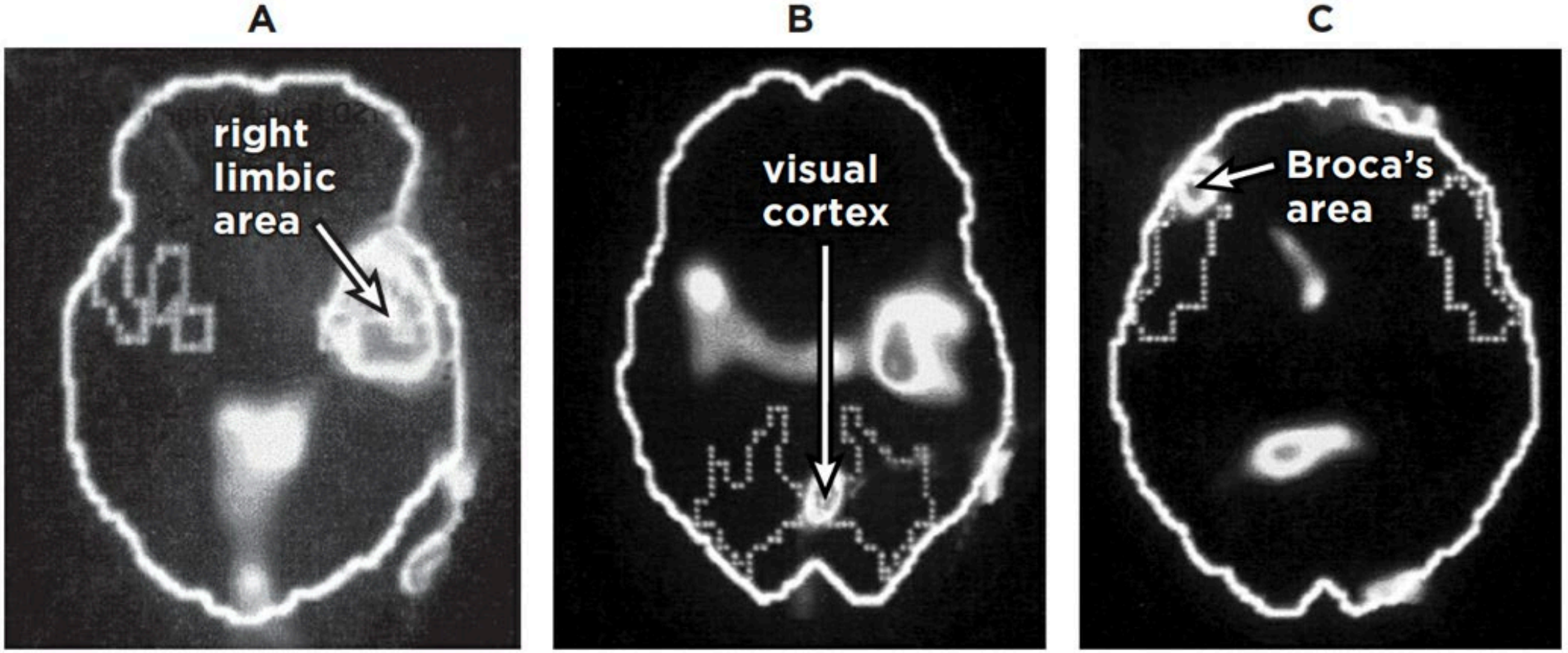
Use Mood Disorder Questionnaire to help you screen for this. If in doubt, refer…

***Cannot be diagnosed if these symptoms are in the context of substance use.**

My Approach to Chronic Disease



Brain scans of people who have gone through traumatic events show changes in areas of the brain as if they are continuing to live the trauma



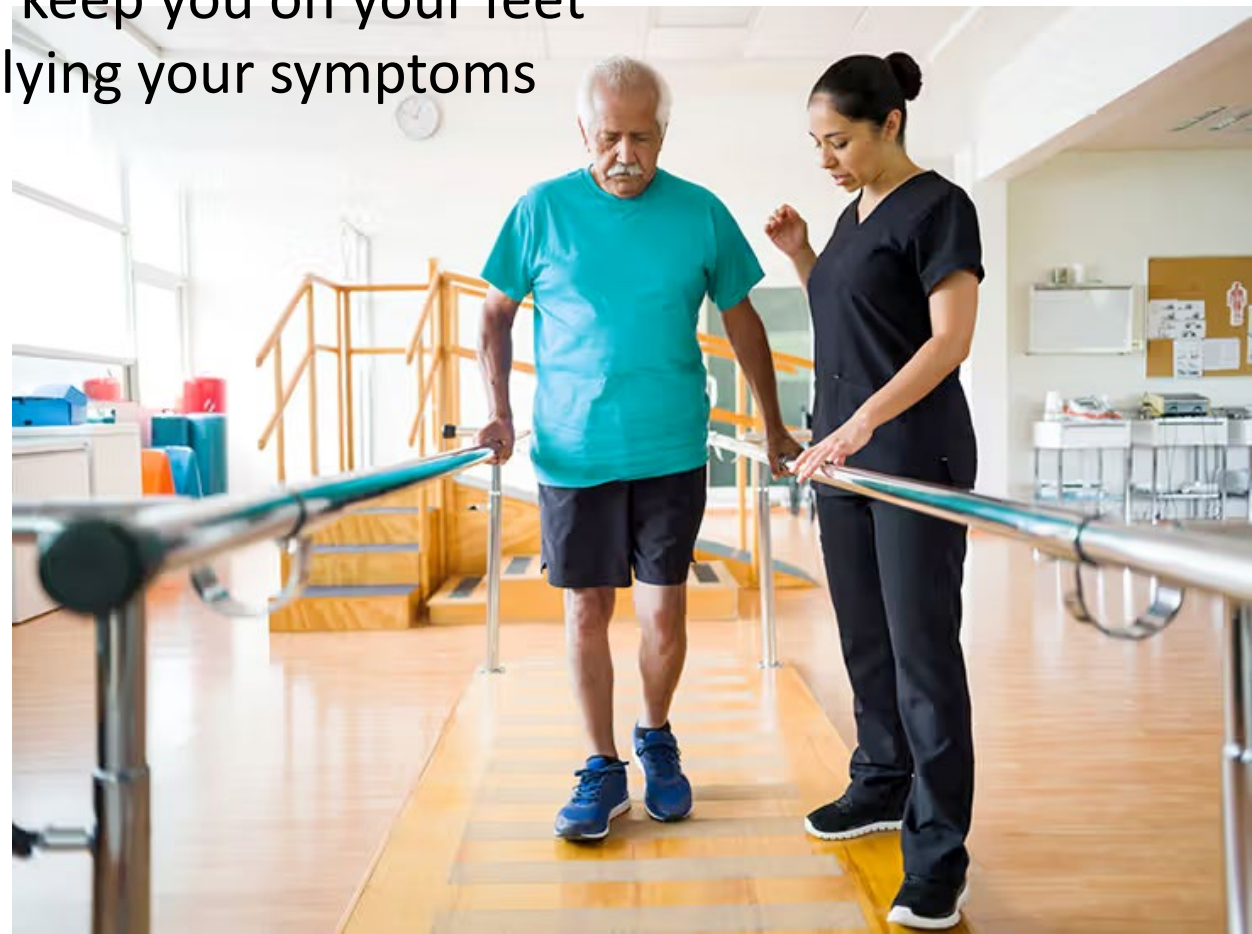
Kolk MD, Bessel van der. The Body Keeps the Score (p. 42). Penguin Publishing Group. Kindle Edition.

My Approach to Mental Health

- Thorough History
  - When did symptoms begin? How bad have they gotten?
  - Trauma history from preconception until now (emphasis on <10 yo)
  - Issues with sleep
  - Psych history (Diagnoses, treatment w/ therapy, meds, hospitalizations, SA)
  - Family History
  - Substance Use – current and past
  - Social History (Spirituality/Religion, Work/School, Family/Friends/Support)
  - Relationship and sexual history
  - Work history

My Approach to Mental Health

- My analogy about healing
  - Medications – get you on your feet or keep you on your feet
  - One foot – healing the wounds underlying your symptoms
  - Other foot – Lifestyle changes
    - Sleep
    - Pursuing Passions/Purpose
    - Spiritual Practice
    - Exercise
    - Social support/synchronicity
    - Diet
    - Creativity
    - Nature



My Approach to Mental Health

- Healing work
  - Psychotherapy
    - CBT and supportive psychotherapy is good at first for coping
    - When patient is ready, deeper trauma work
      - EMDR, Internal Family Systems, Somatic Work, Neurofeedback, etc.
  - Body work
    - Acupuncture, Massage, Lomi Lomi, OMT (especially for postpartum and TBIs)
  - Spiritual Healing
    - Shamanic work, psychedelic integration, Ho'oponopono
  - Energy and Sound Healing

  *Whatever patient finds helpful and does not seem harmful to you

My Approach to Mental Health

- Lifestyle changes
  - **Sleep**
  - Pursuing Passions/Purpose
  - Spiritual Practice
    - Work with their belief system
      - If none, encourage them to explore their beliefs and practices
    - Meditation, Prayer, Qi Gong, Yoga, hiking/connecting in nature
  - Exercise
  - Social support/synchronicity
  - Diet
  - Creativity
  - Nature

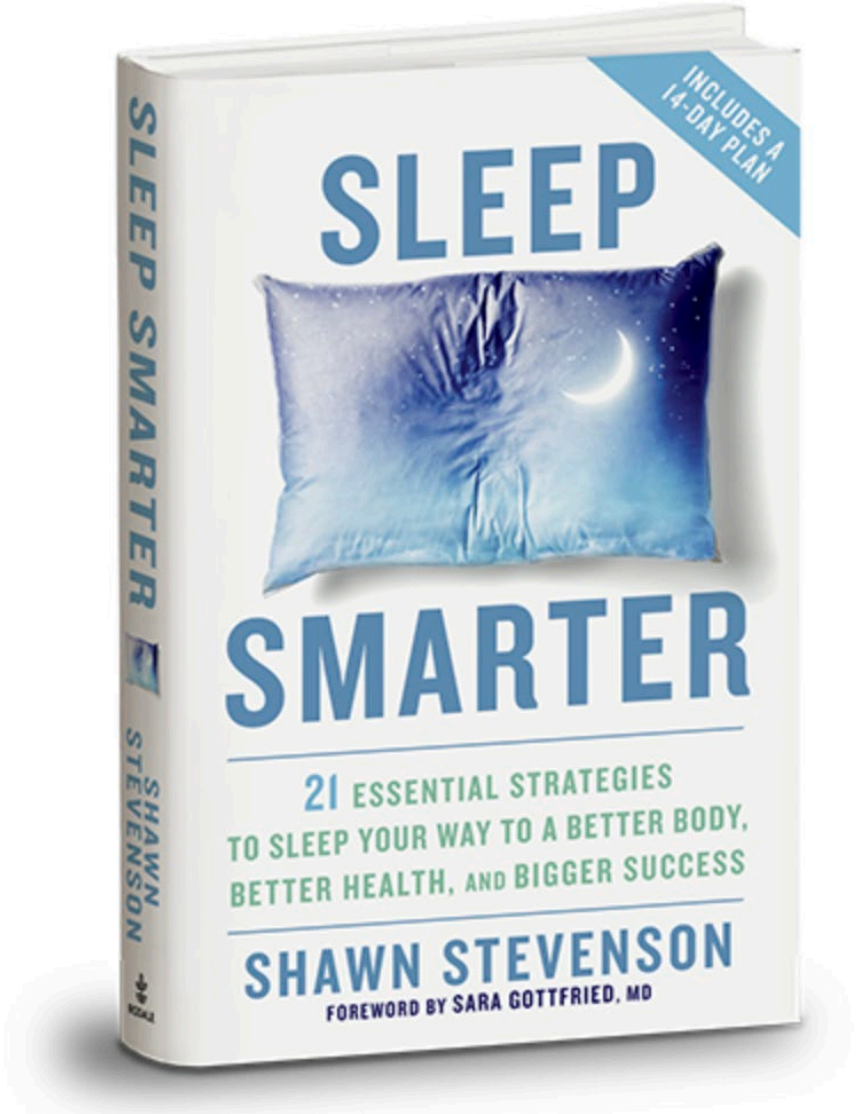
My Approach to Insomnia/Sleep Trouble

- Gather history about their sleep
  - ”Tell me about your sleep...”
  - Duration of actual sleep in hours
  - Problems falling asleep, staying asleep or both. Why?
  - Bedtime – How consistent? Weekdays? Weekends
  - Wake up – Alarm? If not, what wakes them up?
  - Bedtime routine
    - What do they do leading up to going to bed?
    - Are they doing any activities in bed?
    - Screen use?
    - Substance use or meds?

My Approach to Insomnia/Sleep Trouble

- Start with sleep hygiene targeted to issues gathered in the history
  - Bed is a sacred space – sleep and sex only
  - Bedtime: Ideally no later than 10-10:30 PM (11-2 PM is crucial circadian rhythm time – deep sleep vs 2nd wind)
  - Bedtime routine: NO SCREENS 1-2 hours prior, offer relaxing wind down activities: journaling (GLAD recap of day), prayer/meditation, deep belly breathing, teas (Sleepy Time, chamomille, Tulsi/Holy Basil), baths, lavender
  - Sleep environment (dark, cool, quiet or white noisey)
  - Avoid caffeine after noon and other mind-altering substances (EtOH, THC) 3-4 hours before bedtime.
  - Avoid naps after 2 PM, and set alarm for 20 min
  - Maximize sunlight and exercise first thing in the morning

Book for Insomnia/Sleep Trouble



Insomnia/Sleep Trouble

- Cognitive Behavioral Therapy for Insomnia (CBTi) is the gold standard to address insomnia and sleep issues
  - Have them explore this with their therapist if they have one
  - https://freecbti.com/
  - Apps: CBT-i coach, Insomnia coach
  - Get trained yourself if you're interested
    - CBTi Web
    - American Academy of Sleep Medicine (AASM)

Types of Bipolar Disorder

- Bipolar 1 Disorder – Significant mania leading to hospitalization, arrest or serious harm/dysfunction
- Bipolar 2 Disorder – Hypomania with irritability and Depression more prominent
- Cyclothymia AKA “Bipolar 3 Disorder” – Mildest form of bipolar disorder with hypomania and mild to moderate depression
  - More difficult to diagnose

Screening for Bipolar Disorder

- Important to try to screen in those with depression and anxiety
  - Mood Disorder Questionnaire - Can use this before or during encounter
  - Detailed questions when gathering history
    - “Have you ever had any periods where you got little sleep (<5 hrs/nt) for at least 3 nights in a row and feel like you didn’t even need the sleep?”
    - If yes, “Did you find yourself more impulsive during this time to the point where it caused problems for you?”
    - Give examples, such as increased spending causing financial hardship or significant debt, risky sexual behaviors and promiscuity, atypical drug use, etc.
- **SSRIs (especially at higher doses) without mood stabilizers can cause mania or rapid cycling**
  - Irritability, sleeping less, “crawling out of [their] skin” while on SSRI maybe early symptoms – stop SSRI and consider other options.
- When in doubt, REFER

Bipolar disorder Medications

- Guiding principles
  - Minimize Harm
  - Risks vs Benefits
  - Most cases – dosing starts low and go slow
  - Every patient is unique
    - Demographics – Females of childbearing potential, elderly
    - Other conditions and current medications
    - Past medication trials
      - What medication(s) were they on when most stable in the past?
      - Adverse effects vs Allergies
      - Benefits – If denies, in context of substance use?
      - If none, but family history – ask if any family member with BD has responded well to any particular medication(s)

Bipolar disorder Medications

Acute mania

- Decreased need for sleep over the course of days to weeks
- DIG FAST: Distractibility, Irresponsibility/**Irritability**, **Grandiosity**, Flight of Ideas/Racing Thoughts, **Activity increased**, Sleep Decreased, **Talkative**
- Psychotic symptoms: **delusions (paranoid, religious, grandiose**), auditory hallucinations

- Your priority is to get them to ER → Inpatient Psych
- In the meantime:
  - Benzos (Ativan, Valium)
  - Sedating Antipsychotics (Quetiapine, Olanzapine)
  - Antihistamines – Diphenhydramine, Hydroxyzine (50-100 mg)
  - Start Maintenance medications in parallel

Bipolar disorder Medications

- Lithium – First line for Bipolar 1 maintenance with best evidence
  - Towns with lithium that have water sources with lithium have lower rates of suicide, homicide and better mood overall
  - Lithium carbonate – most common dosing - 600-1200 mg QHS
    - No significant benefit for BID or TID dosing
    - Common adverse effects: polydipsia, polyuria, tremor (high level), sedation, neuropathy, thyroid and renal issues long-term
  - Lithium orotate (OTC) – very limited data, dosing unclear but likely more potent with less AE
  - Important to get baseline GFR and TSH/T4
  - Levels whenever changing dose, 6-12 months or as clinically indicated
  - Avoid NSAIDs, ACEi's, diuretics, possibly ARBs -> lithium toxicity
  - Pregnancy and Ebstein's Anomaly: risk ratio was 1.11 for daily doses of ≤600 mg and 3.22 for >900 mg (1st Trimester)

Bipolar disorder Medications

- Depakote (Valproate) – Second line for Bipolar 1 maintenance
  - Derived originally as analog of valeric acid from valerian (root)
  - Originally used for seizures and epilepsy
  - Very effective in preventing mania and helpful in treating acute mania
  - Dosing starts usually around 750 mg with titration to effect (max 60 mg/kg/day)
  - Depakote ER dose is 10-20% higher than DR but only daily (preferably QHS)
  - Avoid in women of childbearing potential (teratogenic), cirrhosis, certain metabolic disorders (urea cycle disorders, mitochondrial disorders)
  - Lots of drug-drug interactions due to liver metabolism (CYP 2C9 and 2c19 inhibitor)
  - Common adverse effects: sedating (QHS dosing preferred), weight gain, tremors, dizziness, LE edema; More serious adverse reactions: liver toxicity, hyperammonemia, thrombocytopenia
  - Labs to help monitor: CMP, CBC, Valproate (-oic acid) Level (right before ER dose or 10 hours after last DR dose before morning dose), metabolic labs (if weight gain observed)

Bipolar disorder Medications

- Carbamazepine/Oxcarbazepine
  - 3rd Line for Bipolar 1 disorder
  - Modestly effective with levels that can be measured
  - Associated with SIADH and hyponatremia
    - for CBZ, the reported estimates are between 4% and 40%, whereas for OXC, they are between 23% and 73%
  - LOTS of Drug-drug interactions (Anticoagulants, Antidepressants, benzos, antipsychotics, grapefruit, alcohol and OCPs)
  - Pregnancy
    - Carbamazepine – teratogenic (neural tube defects, spina bifida, and craniofacial defects)
    - Oxcarbazepine – relatively safe, but associated w/ bleeding, NAS, language devo, ASD

Bipolar disorder Medications

- Lamotrigine
  - Can be helpful in patients who have: concerns about adverse effects of SSRIs or failed multiple SSRIs, screen positive on MDQ but no history of mania, complex trauma/Cluster B personality traits
  - Steven-Johnson Syndrome in Lamictal
    - Rare incidence: between 2-7 cases per million per year
    - Usually in the first few weeks of starting the medication
  - Titrate slowly: start at 25 mg daily and double the dose every 2 weeks
    - Most people start to notice a benefit at 200 mg
  - Can be associated with other rashes (~10% of patients on lamotrigine)
  - Most patients tolerate it well with little to any adverse effects

Bipolar disorder Medications

- Atypical Antipsychotics – Maintenance and bipolar depression
  - Concern for compliance
    - Aripiprazole (Abilify), Risperidone, Paliperidone (Invega)
      - Long-acting injectable options: Abilify Maintena and Aristada, Invega Sustenna, Trinza, Hafyera
  - Good for mood but not psychosis
    - Ziprasidone (Geodon) - BID dosing, dosing can go very high (no clear ceiling)
    - Lurasidone (Latuda) – Taken w/ meals of >350 KCal, helpful for depression, relatively weight neutral
    - Quetiapine (Seroquel) – Quells mania quickly, high metabolic risk, not ideal maintenance med
  - Good for mood and psychosis
    - Olanzapine - Quells mania quickly, high metabolic risk, not ideal maintenance med
    - Clozapine – High side effect profile, REMS (frequent ANC monitoring), BIG GUN!

Bipolar disorder Medications

- Atypical Antipsychotics
  - Most have metabolic adverse effects of weight gain, DM2, HLD, HTN
  - Best to start with metformin and/or topiramate to prevent and plateau
  - Akathisia and dystonia common adverse effects – aripiprazole and risperidone/paliperidone respectively
  - Should assess at least annually for tardive dyskinesia (AIMS assessment)
    - If develops TD, stop medication and look for other options if possible
    - If few options or you feel risk of DC is too high, make sure it is not bothersome to patient and consider treatment (tetrabenazine, valbenazine, clonazepam, Botox)

Bipolar disorder Medications

- Catatonia
  - More common in bipolar disorder than any other condition
  - Episodes of lack of or repeated movement, speech, posturing, agitation, prolonged staring, copying others speech or actions
  - Likely need delirium w/u including head CT
  - First line treatment is benzos, frequent dosing and may need to be very high
    - “Ativan challenge” with 1 mg → If improves, continue treating with benzo while starting neuroleptic/antipsychotic (avoid quetiapine, ziprasidone, lurasidone)
  - If severe to the point of not moving, eating or drinking, need hospitalization to prevent dehydration, malnutrition and/or end-organ damage.

Bipolar disorder Medications

- Benzos
  - To be used for acute mania (scheduled for short periods of time), catatonia (scheduled until resolved) and panic attacks (PRN)
  - Not good sleep medication as it disrupts sleep architecture
  - No recommendations to use benzos on a daily basis beyond 4 weeks
  - Chronic benzos cause more problems down the road
    - Prescribed Alcohol
    - Worsens depression, anxiety, cognitive function (similar to ADHD and/or dementia)
    - High risk of delirium and falls in elderly
  - Advise patients not to drive or do important tasks while under influence
    - Legally, patients can get a DUI and **YOU ARE LIABLE** if you don't warn them in advance and there is any harm caused.

Bipolar disorder

- Coinciding PMDD or menses-related mania
  - Worsened symptoms in week leading up to and during menses
  - Often indicative of a history of sexual trauma
  - Helpful to increase mood stabilizer dose (if possible) in the week leading up to and/or during menses. Can consider acute mania medications as PRNs during this time.

Summary

- Make an effort to screen for bipolar disorder before treating with SSRIs
- Try to approach from a holistic lens
- Importance of doing deeper healing work in parallel with symptom management
- Emphasize lifestyle changes to address their symptoms and overall health day to day
- Be aware of the potential harms of medications used and monitoring that should be done
- Refer when possible…

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Thank you!
My Phone Number

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Questions?
Comments
Thoughts…
Feedback
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