The Interface

Managing Bipolar Disorder in the Primary Care Setting: A Perspective for Mental Health Professionals

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This ongoing column is dedicated to the challenging clinical interface between psychiatry and primary care—two fields that are inexorably linked.

ABSTRACT

Bipolar disorder affects between 1.3 percent and 1.6 percent of the general population. According to available evidence, prevalence rates appear to be even higher in primary care settings. The diagnosis and management of patients with bipolar disorder are potentially complicated by a number of factors, including under-diagnosis due to the predominance of depressive symptoms; high levels of psychiatric comorbidity; a comparatively high suicide rate; continuing controversies in the pharmacological management of the disorder; and a potentially elevated cost-of-care contributed by the prescription of brand-name medications as well as laboratory monitoring at baseline and intermittently for lithium and atypical antipsychotics and serum levels for lithium and some anticonvulsants. All of these factors seem to result in an understandable hesitancy on the behalf of primary care clinicians to diagnose and assume care for these complex patients. Mental health professionals need to remain mindful of these issues when arranging dispositions for patients.

KEY WORDS

Bipolar, bipolar disorder, primary care

INTRODUCTION

Without question, bipolar disorder is a challenging and complicated Axis I dysfunction to effectively diagnose and treat. Given the extensive mental health needs of the general population, it is understandable that a portion of the care of these individuals might fall to primary care clinicians. However, in the case of bipolar disorder, there are a number of understandable concerns about rendering care for these patients in primary care settings. In this edition of The Interface, we discuss several of these issues in an effort to promote awareness in the mental health community about the complexities of bipolar patients being diagnosed and managed by primary care clinicians.

THE PREVALENCE OF BIPOLAR DISORDER

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*,[1] the prevalence of bipolar disorder in the general population is between 1.3 percent and 1.6 percent. These rates appear to be in line with data from the National Comorbidity Survey Replication study, which reported the prevalence of bipolar I and II disorders in a community sample at 3.9 percent.[2] Collectively, findings indicate that a substantial minority of individuals in the general

population suffers from this phasic mood disorder.

As for the prevalence of bipolar disorder in the primary care setting, we could only find one applicable article. In this 2005 study, Das et al[3] examined the prevalence of bipolar disorder in a low-income, urban, general medicine clinic. Among the 1,157 participants, 9.8 percent screened positive on the Mood Disorder Questionnaire, a 13-item, yes/no, self-report measure for detecting both bipolar I and II disorders.

Two related studies have examined the prevalence of bipolar symptoms in select primary-care patient samples presenting with mood and/or anxiety symptoms. In the first, Manning et al[4] examined 108 consecutive anxious/depressed outpatients in a family medicine clinic and found that 25.9 percent suffered from bipolar symptoms or cyclothymia. In the second family medicine study, Hirschfeld et al[5] examined patients with depression who were being prescribed an antidepressant. In this well-delineated sample, 16 percent of participants reported a prior diagnosis of bipolar disorder; 21.3 percent scored positively on the Mood Disorder Questionnaire; and based upon a subsample that underwent evaluation with a semi-structured interview, the estimated prevalence of bipolar disorder in this cohort was 27.9 percent. These collective studies indicate that bipolar disorder may be more concentrated in primary care settings, compared with community samples.

DIAGNOSIS AND TREATMENT: CHALLENGES IN PRIMARY CARE

There are a number of potential quagmires for primary care clinicians when diagnosing and treating patients with bipolar disorder. While many of the same issues apply to psychiatric clinicians, they may be intensified in busy primary care clinics in which providers must maintain a broad general knowledge base and attend to multiple medical issues.

Diagnostic difficulties. Bipolar disorder can be clinically challenging to diagnose in any treatment setting because depressed mood is present more often and is lengthier than manic/hypomanic mood.[6] In addition, over 60 percent of patients initially present with depression (i.e., there is no clinical evidence of a prior manic/hypomanic episode), thereby obscuring the presence of a phasic mood disorder.[7] Because depressive symptoms tend to dominate the clinical picture, they lend themselves well to sculpting a depression diagnosis. In keeping with this impression, Frye et al[8] found that 78 percent of primary care physicians failed to detect or misdiagnosed bipolar disorder.

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Extensive psychiatric comorbidity. Patients with bipolar disorder tend to be characterized by extensive psychiatric comorbidity. In a review of the literature, Krishnan[9] found that bipolar disorder is frequently comorbid with substance use disorders as well as anxiety, attention deficit hyperactivity, eating, cyclothymic, and Axis II disorders. The preceding findings echo those of Singh and Zarate,[10] who reported substantial comorbidity of bipolar disorder with substance use, anxiety, impulse control, eating, and attention deficit hyperactivity disorders. These combined findings indicate that bipolar disorder is likely to demonstrate multiple layers of psychiatric complexity. Note that a number of these diagnoses require highly specialized treatment (e.g., substance use disorders, eating disorders)—treatment that may be extremely difficult to access and monitor from a primary care site.

Heightened suicide risk. According to the existing literature, individuals with bipolar disorder have a substantially higher rate of suicide attempts/completions than persons with other types of psychiatric disorders. For example, Ostracher and Eidelman[11] report that the lifetime rate of suicide in these patients may be as high as 19 percent and suggest that bipolar disorder is perhaps the most lethal psychiatric disorder. In addition, Ostracher and Eidelman[11] indicate that in untreated cases of bipolar disorder, the suicide rate is 30 times that encountered in the general population. These findings echo the conclusions of Pompili et al,[12] who indicated that the rate of suicide completion in patients with bipolar disorder is 20-fold higher than the general population. Understandably, suicide attempts are a considerable challenge to manage in the primary care setting.

Controversies with pharmacological treatment. The field of bipolar disorder is riddled with pharmacological treatment controversies. For example, while antidepressant monotherapy for the

depressive phase of the illness has traditionally been discouraged due to the risk of inducing a manic episode or increasing the frequency of mood cycles,[13] a recent examination of fluoxetine monotherapy in depressed bipolar II patients[14] concluded that solo antidepressant therapy can be fairly effective. In addition, in a review of available controlled trials, Gijsman et al[15] found that antidepressants were effective in the short-term management of bipolar depression. Which position does the clinician abide by?

In addition to the antidepressant controversy, there appears to be an undefined variability in the effectiveness of individual anticonvulsants in the treatment of bipolar disorder.[16] Following and integrating the literature on anticonvulsant prescription in bipolar disorder seems to be beyond the scope of family or internal medicine clinicians.

Finally, the use of antipsychotic medications and lithium for the treatment of manic/hypomanic episodes is potentially compromised by a notable risk for side effects, which oftentimes include substantial weight gain.[17] Unfortunately, weight concerns and the associated conditions of diabetes, hypertension, hyperlipidemia, joint stress/pain, and asthma are rampant diagnoses in primary care settings—diagnoses that may be worsened by medication-induced weight gain. In addition, lithium may impair thyroid functioning.

All of the preceding issues contribute to primary care clinicians' perplexity about medication selection in the treatment of bipolar disorder. In support of this impression, in a 2006 study, Stang et al[18] examined the knowledge base of primary care physicians with regard to bipolar medications and found that no participant correctly identified all of the medications approved by the United States Food and Drug Administration for the treatment of this disorder.

According to Hajek et al,[20] even among patients with clearly recognized diagnoses of bipolar disorder, attaining reasonable levels of psychosocial functioning through primary care treatment may be compromised by the chronic course of illness, rapid cycling, suicidal behavior, psychiatric comorbidity, hypothyroidism, and diabetes mellitus.[19]

Elevated cost factors. Many of the medications used in the treatment of bipolar disorder result in higher costs than those used in other psychiatric disorders because of the prescription of brand-name atypical antipsychotics, the need for baseline and intermittent laboratory monitoring for some medications (e.g., lithium, atypical antipsychotics), and the use of serum levels for assessment and dosage adjustment of lithium and some anticonvulsants. This additional expense may threaten patient adherence with treatment, resulting in another challenge for primary care clinicians.

Summary. All of the preceding factors contribute to an understandable reluctance by primary care clinicians to treat patients with bipolar disorder. According to Hajek et al,[20] even among patients with clearly recognized diagnoses of bipolar disorder, attaining reasonable levels of psychosocial functioning through primary care treatment may be compromised by the chronic course of illness, rapid cycling, suicidal behavior, psychiatric comorbidity, hypothyroidism, and diabetes mellitus.[19] Stang et al[18] have described bipolar treatment in the primary care setting as, "difficult and time-consuming." In addition, in a 1987 article, 74.3 percent of primary care physicians rated their ability to treat bipolar patients as "low."[20]

A RECENT OPINION POLL

Through a cross-sectional survey, we recently examined the attitudes of primary care clinicians with regard to bipolar treatment.[21] Although the sample size was very small (N=38), findings provide a glimpse into the concerns experienced by clinicians in these settings. Two-thirds of respondents affirmed that they prescribe psychotropic medications to bipolar patients in their practices. However, two-thirds also indicated that primary care clinicians should prescribe medications to bipolar patients "rarely" or "on occasion;" no respondent endorsed the option of "always." Regarding the diagnosis and treatment of bipolar disorder, all means on the Likert-style scales assessing "comfortability" leaned in the uncomfortable direction, with the prescription of antipsychotics, both typical and atypical, being the least comfortable of all items.

CONCLUSION

As mental health clinicians continue to struggle with high-volume case loads and limited resources, there is an understandable tendency to attempt to allocate patient care to primary care clinicians. However, in the case of bipolar disorder, a number of factors understandably result in some reluctance by primary care clinicians to diagnose and manage these complex

and challenging patients. We believe that it is essential that mental health professionals remain aware of this possible reluctance on the behalf of primary care clinicians, and to appreciate that each specialty and individual must ascertain his or her respective scope of practice.

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