Subtle Presentations of Bipolar Disorder:
What a Client's Life Story Can Reveal

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February 17, 2018

Objectives

- This workshop will discuss differential diagnoses, clinical examples and treatment approaches for milder forms of bipolar disorder.
- Will include a focus on how clinicians can improve diagnostic accuracy through skillful interviewing, particularly by engaging the client in the diagnostic process by framing their symptoms in the context of their broader life story, the use of screening questionnaires and engagement of family members to obtain a more thorough history.

Case Example

- 28 year old man presents with a chief complaint of lack of concentration and inability to focus for approximately the past 8 months.
- Inability to complete projects on the job → poor performance review
- Denied current symptoms of depression, anxiety or psychosis, stating that his main concern was his inability to concentrate and the negative impact on his job
- Interview notable for high level of motor activity, most questions answered in haste, thought process somewhat circumstantial and jumped from topic to topic

Jabbar Q, Ansari I, Shah A, Shah AA. A 28-Year-Old-Man with Lack of Concentration and Inability to Focus. Psychiatric Annals. 2017 June;47(6):285-286

Thoughts?

Differential Diagnosis?

Case Example

- Clinician diagnosed adult ADHD
- Prescribed Amphetamine/Dextroamphetamine 10 mg daily, increasing the dose to by 10 mg every week up to a dose of 30 mg daily

- 3 weeks later the patient returned for follow up and reported some improvement in his ability to focus and concentrate

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Case Closed

...or is it?

2 months after the initial visit…

- The patient returns with his girlfriend of 8 years who is concerned about his worsening behavior:
  - Extraordinarily energetic
  - More interested in activities in the past few months
  - Every weekend wants to go scuba diving or bungee jumping
  - Spending a lot of money on unnecessary shopping even though it had put him in serious debt
  - Not acting like his usual introverted self

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Pt's girlfriend provides further history…

- The patient had had an episode of depression 4 years ago that had been treated with medication and lasted for 8 months

- The patient, however, expressed satisfaction with his progress; he felt that the stimulant medication had helped as he was feeling more successful at work and in his interpersonal interactions

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Thoughts?

What would you want to do next?

Additional history obtained from the pt's girlfriend...

7 years ago…

- Episode with similar behavior
- Subsided after about a week and he never sought medical help
- Led to more than $10K in debt
- Cost him his job

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More recently…

- Decreased sleep over the past 6-8 months
- In the past few weeks, sleeping only 2 to 3 hours out of 24 hours
- Hyperenergetic
- Spending a lot of money, accumulating $20K of debt over the past few months

Also…

- Changed jobs 4 times in the past 8 months due to his poor performance
- Talks fast
- Stays up late at night to clean his house
- Is always “on the go”

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A change in diagnosis...

- Based on the added history, the diagnosis was changed to Bipolar II Disorder
- ADHD diagnosis was removed
- Stimulant was immediately discontinued
- Quetiapine was prescribed at a dose of 100 mg qhs and increased to 400 mg qhs

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Follow Up

- 1 week later…
  - the patient's symptoms had drastically improved
- 1 month later…
  - the patient reported that his work performance had also improved and he had received positive feedback from his supervisor
- The patient was continued on Quetiapine 400 mg qhs and remains stable

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Could the diagnosis of Bipolar II have been made sooner?

- The foundation of all mood disorders is a ‘‘sustained emotion that colors the perception of the world’’
(APA, 1994)

Bowden, CL, A different depression: clinical distinctions between bipolar and unipolar depression. J. Affect Disord. 2005 Feb;84(2-3):117-25

- Mood disorders are differentiated into unipolar depressive disorder and bipolar disorder by the type of mood alteration, its severity, and its longitudinal pattern.

- Major distinction in bipolar disorder is the presence of mania or hypomania at some time during the disease course.

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DSM-5 Criteria: Manic Episode

Distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalization is necessary).

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition

DSM-5 Criteria: Manic Episode

During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior:

- *Inflated self-esteem or grandiosity*
- *Decreased need for sleep (feels rested after only 3 hours of sleep)*
- *More talkative than usual or pressure to keep talking*
- *Flight of ideas or subjective experience that thoughts are racing*
- *Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed*
- *Increase in goal-directed activity (either socially, at work, school, or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity).*
- *Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).*

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition

DSM-5 Criteria: Manic Episode

The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

The episode is not attributable to the physiologic effects of a substance or to another medical condition.

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition

“DIGFAST”

- **D**istractibility
- **I**ndiscretion
- **G**randiosity
- **F**light of ideas
- **A**ctivity increase
- **S**leep deficit
- **T**alkativeness

DSM-5 Criteria: Hypomanic Episode

- The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.
- Lasts at least 4 consecutive days (vs. one week)
- The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization.

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition

Hypomania

- Heightened activity, energy, and productivity associated with these episodes likely to not be viewed negatively, therefore may remain unreported by the patient.

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ADHD

- Desire to go to sleep but unable to quiet the mind
- Moods congruent and shift rapidly
- Thoughts "jump"
- **Always present**

BPAD

- No desire to sleep due to excess energy
- Mood incongruent and shifts are usually sustained
- Thoughts "race"
- **Cyclical/episodic**

- **Poor sleep**
- **Mood instability**
- **Bursts of energy/ restlessness**
- **Talkativeness**
- **Disorganization**
- **Distractibility**
- **Impulsivity**
- **Poor focus**

Jabbar Q, Ansari I, Shah A, Shah AA. 2017
Dodson W. 2013

BPAD or ADHD...or both?

- Adult ADHD affects 4.2% - 4.4% of people in developed countries such as the U.S.
- BPAD affects 2.6% of the U.S. population
- Estimated that 15-17% of people with BPAD have ADHD
- Estimated that 6-7% of people with ADHD also have BPAD

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Dodson, W. Is it Bipolar or ADHD? ADDitute Magazine. 2013. https://www.additudemag.com/wpcontent/uploads/2017/01/10212_Understand-Conditions_is-it-bipolar-disorder-or-adhd.pdf

Unipolar MDD or Bipolar II Disorder?

A different type of depression

- Patients in a bipolar depressed phase
  - Fewer signs and symptoms of anxiety, physical complaints, and anger.
  - Tend to be more quietly withdrawn, mentally and physically slowed down and have hypersomnia.

- Patients with unipolar depressive disorder
  - More mentally and physically active, but with more somatic complaints, sleep disturbances, anxiety, and anger.

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Other possible clues: BPAD vs. Unipolar MDD

- Co-occurring or Past Substance Abuse
  - More than 60% of BPAD patients affected
  - Higher than any other Axis I disorder
- History of Postpartum Depression

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Other possible clues: BPAD vs. Unipolar MDD

- Positive Family History of Bipolar Disorder
  - Similar rates of + FH for MDD (54-58%)
  - **Signficant difference in rates of + FH for BPAD**
    - **41.9%** of the patients with BPAD had a + FH of BPAD vs. 5.2% and 8.3% of the patients with MDD in 2 separate studies. *Overall p <0.001.*

Perlis RH, Brown E, Baker RW, Nirenberg AA. Clinical features of bipolar depression versus major depressive disorder in large multicenter trials. Am J Psychiatry. 2006 Feb;163(2):225-31

Other possible clues: BPAD vs. Unipolar MDD

- Number of depressive episodes
  - BPAD patients: 52.8% had **>25 depressive episodes**
  - MDD patients: 51.7% – 54.9% had only **1-5 depressive episodes**
  - Only 1-3% of MDD patients had >25 episodes of depression

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Other possible clues: BPAD vs. Unipolar MDD

- Earlier age of depression onset among patients with BPAD
  - Depression is likely to present earlier (by about 6 years) in patients with BPAD than with unipolar MDD.
  - Mean age of illness onset 21.2 years for the BPAD patients vs. 29.7 and 29.0 years for the MDD patients. *P <0.001*
  - Childhood diagnosis of depression

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Consequences of Misdiagnosis

- Lack of proper therapy with mood stabilizers may lead to suboptimal resolution of symptoms.
- Use of antidepressants for patients with bipolar disorder without concomitant use of a mood stabilizer may increase the risk of manic switch, a mixed state, or accelerated cycling.
- Most suicides in bipolar disorder occur during depressive episodes or mixed states with prominent depression.
- **Greater lifetime risk of at least 1 suicide attempt in BPAD**
  - **25-50% among patients with BPAD vs. 15% reported for patients with unipolar MDD**

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Risks of delayed mood stabilizer treatment

- Increased healthcare costs
- Increased risk of hospitalization
- Increased risk of suicide

Singh T, Rajput M. Misdiagnosis of Bipolar Disorder. Psychiatry (Edgmont). 2006 Oct; 3(10): 57-63

Clinical Rating Scales

- YMRS (Young Mania Rating Scale)
- IDS-C (Inventory of Depressive Symptomatology)
- MADRS (Montgomery-Asberg Depression Rating Scale)
- Mood Disorder Questionnaire (MDQ)
  - Sensitive and very specific
  - Easy to administer

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The Mood Disorder Questionnaire

Has there ever been a period of time when you were not your usual self and...

- ...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 you didn't really miss it?
  ...you were much more talkative or spoke much faster than usual?

http://www.sadag.org/images/pdf/mdq.pdf

Rating scales are helpful, but nothing can replace a thorough and skillful clinical interview

Gathering the history in the context of the client's broader life story

“What brings you in, and what can I do to help?”

“Tell me about yourself and your background…where were you born and raised?”

- What was life like for you growing up?
- Did you experience any major challenges in your childhood?
- Were you involved in any sports/activities?
- Did you go directly from high school to college?
- Did you finish college on time?
- What kind of work have you done?

- What would your life look like if you were able to feel the way you want to feel?

What the life story can reveal... and why it is important

- Are they a survivor of childhood abuse?
  - An indication of resilience
- Did they make it through college on time?
  - An indication of severity
    - Earlier vs. later onset
    - Judgment and ability to keep it together/keep symptoms under wraps
- Any gaps in employment history?
- Relationship status/relationship history?

Conclusion

- Identifying subtle cases of bipolar disorder is a clinical challenge
- Clinically relevant differences in
  - Patient characteristics
  - Clinical course
  - Diagnostic features
  - Medication response
- Awareness of these distinctions and having a low threshold for suspecting bipolar disorder can greatly improve recognition and appropriate management
- Screening tools can assist in the diagnostic process, but nothing replaces a careful and thorough history
- Framing the history in the context of the patient's broader life story aids in diagnostic accuracy and also has therapeutic value

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Clinical Pearls

- If I have any suspicion of a bipolar diagnosis, I will not start an antidepressant right away
  - will request that the patient complete a release of information and/or bring in a family member to their next visit so that I can interview them
- I almost always send the patient home with several questionnaires for them and their family to complete, including a mood disorder questionnaire.
- I rarely prescribe a stimulant following an intial evaluation.
  - When prescribing stimulants, I give 7-14 day prescription so that the patient must return for follow up and reassessment before the prescription is continued
- I use the client's story and the way they tell their story to guide areas for further exploration and strengths-based work

Even so...it's still possible to miss things...

Questions?

References

- Bowden, CL. A different depression: clinical distincions between bipolar and unipolar depression. J. Affect Disord. 2005 Feb;84(2-3): 117-25
- Dodson, W. Is it Bipolar or ADHD? ADDitute Magazine. 2013. https://www.additudemag.com/wpcontent/uploads/2017/01/10212_Understand-Conditions_is-it-bipolar-disorder-or-adhd.pdf
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