Promoting Treatment Adherence in Schizophrenia: Engagement Strategies for Health Care Providers, Case Managers, and Advocates

Evidence-Based Diagnostic Criteria for Bipolar Disorder
A Resource for Providers

Frameworks resources are intended for educational purposes only and are intended for healthcare professionals and/or payer representatives. They are not intended as, nor are they a substitute for, medical care, advice, or professional diagnosis. Healthcare professionals should use independent medical judgment when considering Frameworks educational resources. Those seeking medical advice should consult with a healthcare professional. Frameworks resources are not intended as reimbursement or legal advice. Users should seek independent, qualified professional advice to ensure their organization is in compliance with the complex legal and regulatory requirements governing healthcare services, and that treatment decisions are made consistent with the applicable standards of care. Frameworks is sponsored by Otsuka Pharmaceutical Development & Commercialization, Inc.
Bipolar disorder is a chronic mental illness and refers to a spectrum that encompasses several diagnoses, including bipolar I, bipolar II, and cyclothymic disorder. Disorders on this spectrum are common, affecting about 2.8% of the United States population. Conditions on this spectrum involve significant and sometimes dramatic shifts in mood, energy, and activity levels.

**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%. 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.

**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%. 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.

**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.

**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.
Negative consequences may not be limited to mental health; patients with untreated bipolar disorder have higher rates of death from cardiovascular causes.\textsuperscript{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.\textsuperscript{9}

Patients may also experience a series of depressive episodes before ever experiencing a manic, hypomanic, or mixed episode.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{5}

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

Medically, patients with bipolar disorder have a high rate of comorbidities, including diabetes, cardiovascular disease, hepatitis C virus infection, obesity, and migraine.\textsuperscript{11} Patients with bipolar disorder may be at an elevated risk of not following preventative health measures.\textsuperscript{12}
Evidence-Based Diagnostic Criteria for Bipolar Disorder

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 symptoms2:

- 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:

- 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:

- 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.

Information a provider may wish to consider includes:

- 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.\textsuperscript{15} It is frequently cited as a barrier to mental healthcare and is associated with reduced treatment seeking.\textsuperscript{16} Bipolar disorder is common in primary care settings.\textsuperscript{8} Reducing discrimination in these settings may help the chances of effective screening and early intervention for mental health conditions.\textsuperscript{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.\textsuperscript{17}