Chapter 1: The Impact of Bipolar Disorder and PTSD on Primary Care Patients and the Role of Collaborative Care in Treatment

Bipolar disorder and posttraumatic stress disorder in Primary Care

Bipolar disorder is a chronic mood disorder occurring in approximately 4.5% of the general population. The prevalence is higher in primary care settings where up to 10% of patients experiencing depression symptoms may have a bipolar disorder. Individuals with bipolar disorder experience mood episodes including depressive, hypomanic and manic episodes, along with chronic mood symptoms and associated functional impairment. Co-occurring psychiatric illnesses such as anxiety disorder, and substance use disorders such as alcohol use disorders, commonly occur in individuals with bipolar disorder. Patients with bipolar disorder experience depressive symptoms more often than manic or hypomanic symptoms, and can experience residual mood symptoms in between full mood episodes. Accurate recognition of bipolar disorder is challenging because most patients with bipolar disorder will present with depression, and patients may have difficulty recalling prior hypomania or mania. The majority of patients with current bipolar depression also experience co-occurring manic symptoms. The STEP-BD study (Sachs GS, et al. Effectiveness of adjunctive antidepressant treatment for bipolar depression. N Engl J Med. 2007;356:1711-1722) revealed that over three-quarters of patients experiencing bipolar depression also experience co-occurring manic symptoms. The most commonly occurring manic symptoms during bipolar depression were racing thoughts (66%) and distractibility (60%).

Posttraumatic stress disorder (PTSD) is an anxiety disorder affecting an estimated 7.7 million American adults, according to the NIMH. Psychological distress following exposure to a traumatic event is the primary symptom of PTSD. PTSD can affect anyone who has been exposed to a traumatic event but rape survivors and military combatants are particularly at risk. The onset of symptoms generally occurs within the first three months after exposure to the traumatic event, but they can be delayed months or even years. Up to 50% of people diagnosed with PTSD have chronic symptoms (Kessler et al, 1995; Breslau et al, 1991; Kessler et al, 2000). Symptoms can include but are not limited to, intrusive thoughts and recollections of the trauma, emotional numbing, and avoidance. Persons diagnosed with PTSD are at an increased risk for comorbid depression and substance use disorders. The World Health Organization suggests there will be an increase in burden that PTSD will have globally due to traumatic events generally associated with PTSD (e.g., traffic accidents, war-related injuries, etc.). PTSD is slated to become a major global public health problem (Davidson, 2001).

Bipolar disorder and PTSD have a profound impact on functioning, quality of life, and health care costs.

Bipolar disorder causes significant psychosocial impairment such as job and relationship loss, and interpersonal problems. The level of psychosocial impairment and reductions in quality of life in individuals with bipolar disorder encountered in primary care is as severe as in those encountered in specialty mental health care settings. Bipolar disorder is also associated with health risk behaviors such as smoking and sedentary activity level. Approximately 50% of individuals with bipolar disorder smoke. Patients with bipolar disorder experience a 10-20 year reduction in life expectancy compared to the general population due to a significant burden of general medical problems, which occur at an earlier age in individuals with bipolar disorder. Patients with greater than 21 years of bipolar disorder illness have a significantly higher burden...
of general medical illnesses compared to patients with 10-20 years and 0-9 years of bipolar disorder illness duration, independent of patient age.

PTSD is associated with significant morbidity and comorbidity. Recent studies show greater levels of disability, use of welfare, use of prescription medication and healthcare visits, as well as work impairment, to as much as four days per month (Amaya-Jackson et al, 1999; Greenberg et al, 1999; Kessler, 2000). Individuals with PTSD also demonstrate impaired resilience with greater difficulty coping with stress and adversity when compared to the general population, primary care outpatients and those with depression or other anxiety disorders. (Connor and Davidson, 2003). Increased rates of attempted suicide have been noted in PTSD, and the adverse physical health consequences related to PTSD are enormous (Davidson et al, 1991; Boscarino, 1997). There is mounting evidence that PTSD is a risk factor for medical illness (Schnurr & Green, 2004). Among all anxiety disorders, PTSD was found to be the most costly with, among other things, substantial work loss and/or cutback (Greenberg et al, 1999).

Few people with complex psychiatric conditions in rural areas receive specialty mental health services. The overall shortage and geographic maldistribution of mental health specialty providers means that access to specialty mental health care is severely limited in rural and urban underserved areas. Even people with complex, chronic psychiatric conditions may be unable to access specialty care and thus, be under the care of a primary care provider.

There are significant gaps between what is known about the efficacy of treatments for bipolar disorder and PTSD under research conditions and the effectiveness of care as it is delivered in most general medical settings. Bipolar disorder and PTSD can both be successfully treated with psychotropic medications, specific forms of psychotherapy, or a combination. Receipt of treatment is associated with an overall shorter course of PTSD (Kessler et al, 1995). (International Psychopharmacology Algorithm Project (IPAP) Post-traumatic stress disorder (PTSD) algorithm notes (2005), page 1-2. retrieved from ipap.org/ptsd/) Mood stabilizing medications are first-line treatments for bipolar disorder whereas antidepressants (specifically selective serotonin reuptake inhibitors) are considered first line treatments for PTSD. Evidence-based psychotherapies are also available for both bipolar disorder and PTSD.

However, few patients in rural or underserved areas receive effective treatments for bipolar disorder or PTSD in primary care. Many people who are referred to specialty mental health services do not follow-up on such referrals, and people who are started on psychotropic medications in primary care often do not stay on the medications long enough for them to have the desired effect.

A number of barriers prevent people from receiving effective treatment for bipolar disorder or PTSD in primary care. These include patient barriers such as the lack of knowledge about their condition and negative attitudes associated with mental health conditions, which are considered by many to be a sign of weakness or a flawed character. They also include such instrumental barriers as lack of easy access to mental health specialists or concerns about the costs of treatment. Patients and primary care providers often assume that PTSD or the mood episodes in bipolar disorder are a natural consequence of stressful life events such as medical illness, losses of loved ones, and...
financial stressors. They conclude that under such circumstances, most people would be feel the same way and that treatment would not help. Primary care providers frequently do not have adequate time and resources in the typical brief office visit to adequately address the patient’s acute and chronic physical problems as well as their mental health condition. When patients are started on psychotropic medications, the primary care provider often lacks the capacity to actively follow the patient to make sure he or she gets an adequate trial of the medication.

**Effective disease management models have been developed for the management of chronic mental and medical illnesses in primary care.**

In recent years, a number of systematic approaches to improve care for chronic conditions such as depression, hypertension, and diabetes have been developed and tested in primary care. Such organized models of care have been described as ‘population-based disease management’. These models involve strategic practice redesign, systematic patient education, use of clinical information systems and decision support, and access to expert knowledge and consultation.

**Overview of the Collaborative Care strategy**

The care is delivered by a team of professionals in a primary care clinic. A care manager (CM) in the primary care clinic conducts an initial assessment, provides patient education, and patient activation encouraging patients to become active collaborators in their treatment. The CM coordinates all mental health care with the patient’s regular primary care provider and provides follow-up and care management. The CM is meets weekly with a consulting psychiatrist remotely by telemedicine for consultation. The consulting psychiatrist will see patients for an initial telemedicine-based psychiatric consultation and may also see patients who are not improving as clinically indicated.

The CM supports medication treatment by primary care providers and is also trained to deliver Behavioral Activation (BA) in primary care by the SPIRIT study psychologist. Treatment selection follows a general approach as outlined in Chapter 4.