MOOD FLIPS and BAD TRIPS : WAYS OUT OF THE MAZE

Co-Occurring Disorder Conference

October 1, 2007

Daniel E. Wolf, D.O.

“Face it Fred, you’re lost.”

WAYS OUT OF THE MAZE

- Me; me and my patient; me and my patient and his/her spouse or SO and family / friends

- You; you and your patient, you and your patient and his/her spouse or SO and family / friends

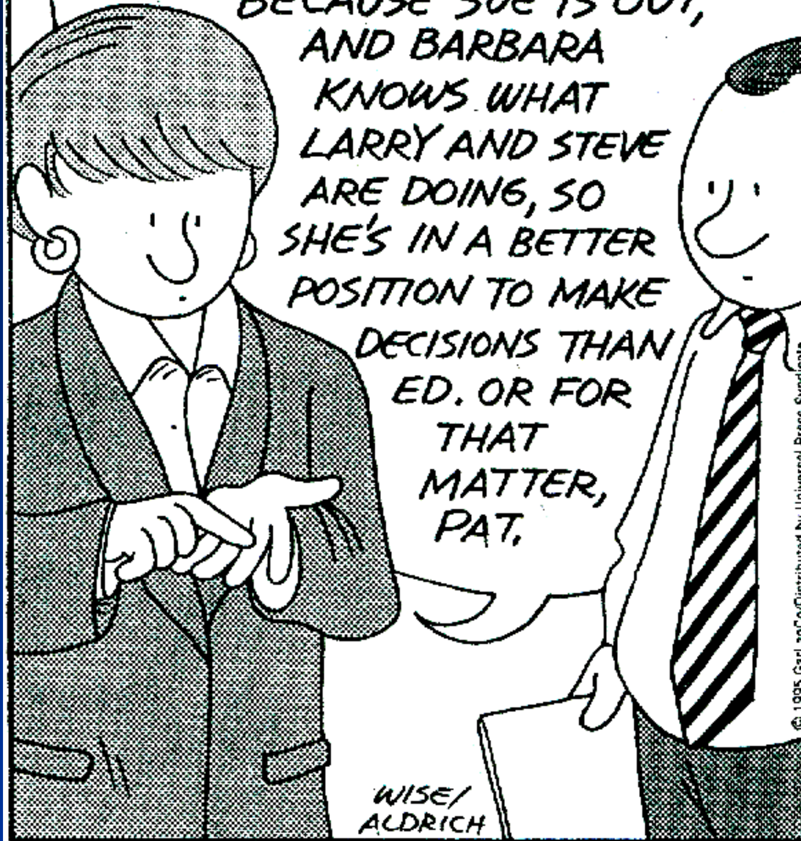
WAYS OUT OF THE MAZE

"There is nothing about a caterpillar which suggests that it will one day become a butterfly."

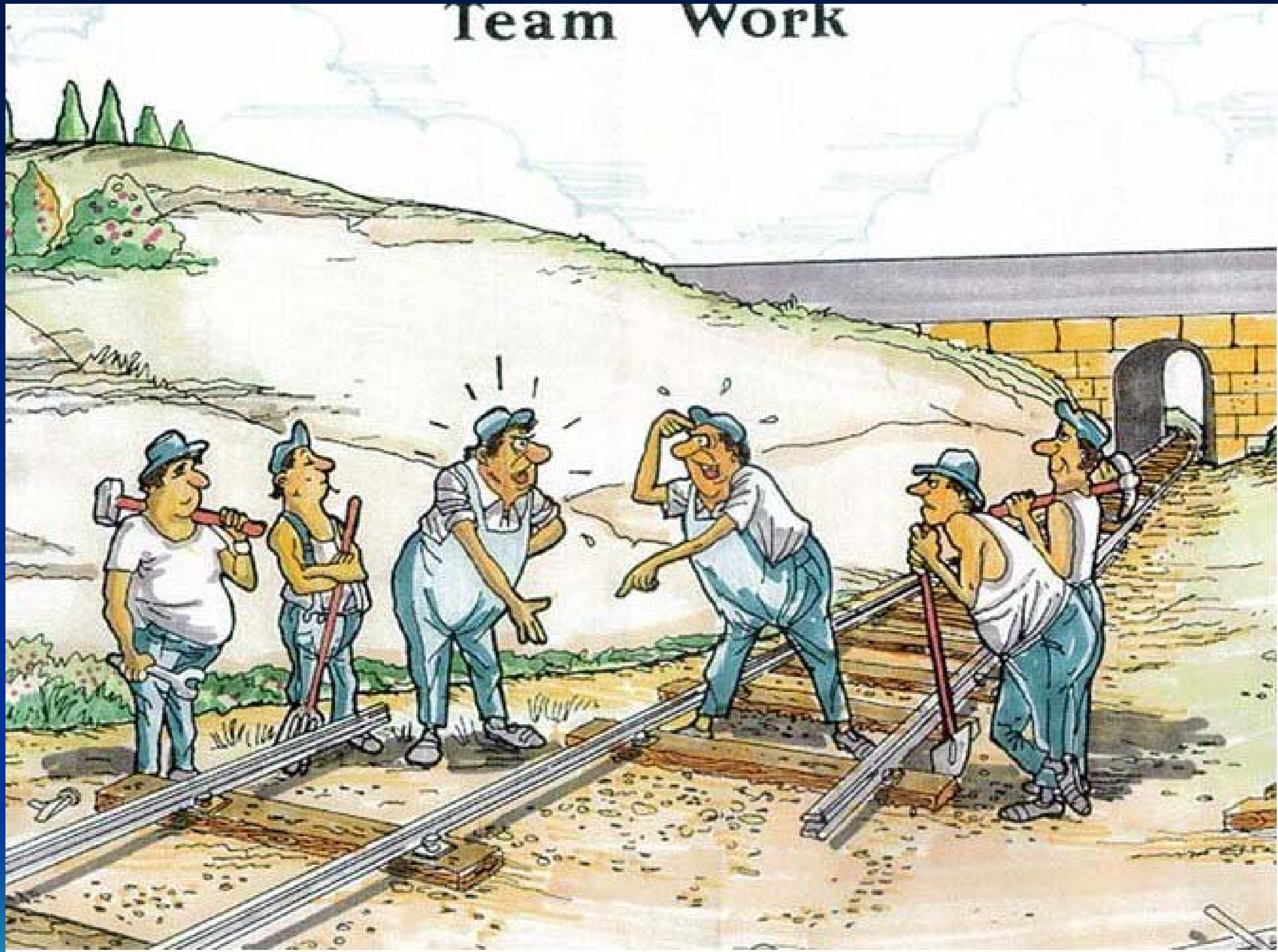
Buckminster Fuller

WAYS OUT OF THE MAZE

- Our patients' treatment team:
  - CDC (inpatient or outpatient CD treatment)
  - Therapists
  - Primary care providers
  - Specialists, inc. psychiatrist, PhD, ARNP, etc.
  - Agencies
    - – Community Mental Health Centers
    - – DSHS, ADATSA, etc.
  - Other



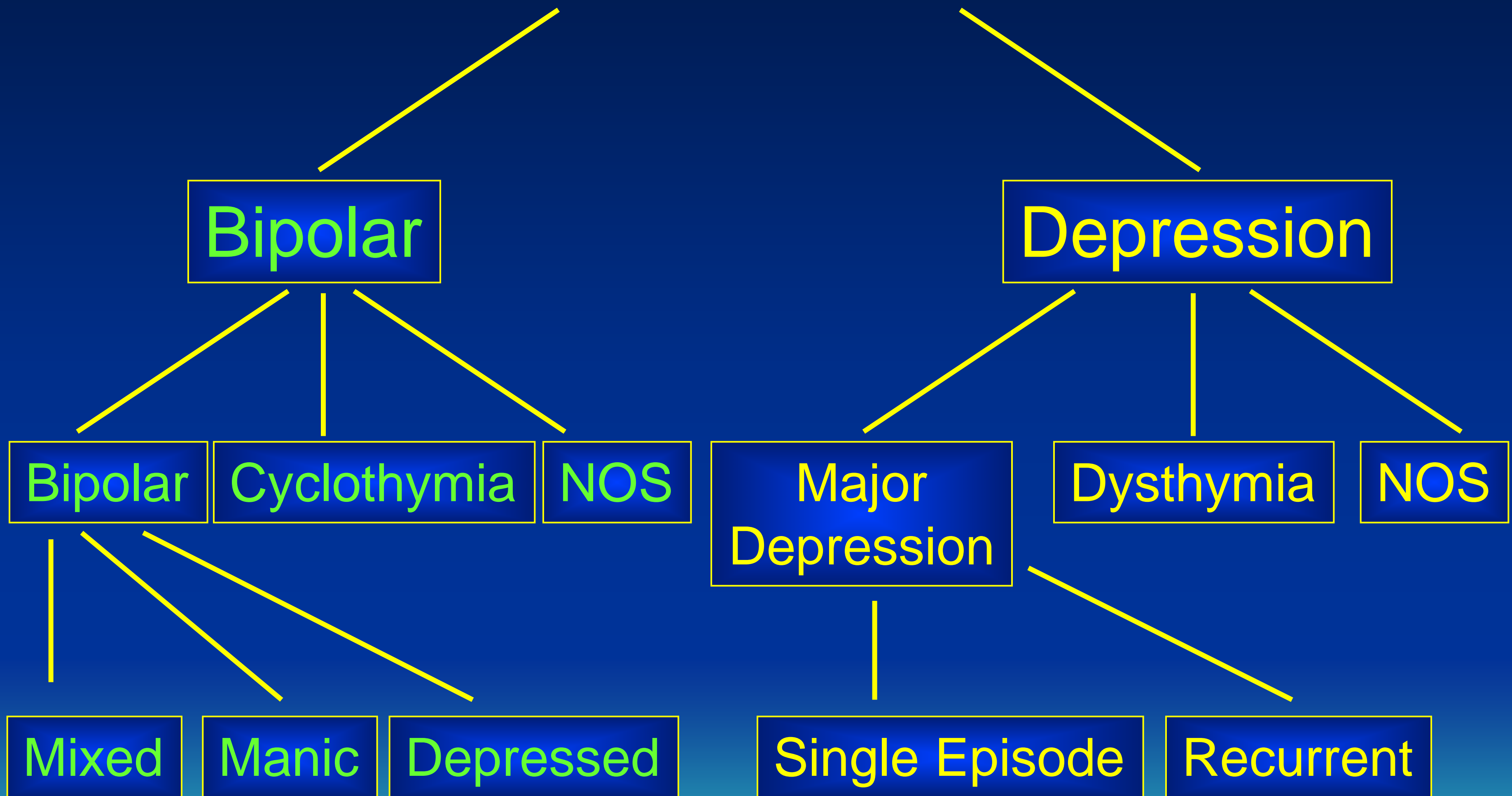
What most companies need is a disorganization chart.


Team Work

CLOSE TO HOME BY JOHN McPHERSON

THESE ARE THE FOUR GUYS WHO WERE IN THAT SKYDIVING ACCIDENT.

MOOD DISORDERS



American Psychiatric Association. *DSM-IV*. Washington, DC: APP;1994.

BIPOLAR TYPES

- Bipolar type I
  - At least one mania
- Bipolar type II
  - At least one hypomania
- Bipolar NOS
  - At least one mania or hypomania but insufficient duration for I or II

MANIC EPISODE

- Elevated, expansive, or irritable mood for ≥1 wk, *plus* ≥3 of the following:
  - Inflated self-esteem or grandiosity
  - Decreased need for sleep
  - Pressured speech
  - Racing thoughts/flight of ideas
  - Distractibility
  - Psychomotor agitation/increase goal-directed activity
  - Excessive involvement in high-risk activities

American Psychiatric Association. *DSM-IV.* Washington, DC: APP;1994.

MANIA: DIGFAST

- Distractibility -- poorly focused
- Insomnia -- decreased need for sleep
- Grandiosity -- inflated self-esteem
- Flight of ideas -- racing thoughts
- Activities -- inc'd goal-directed activities
- Speech -- pressured or more talkative
- Thoughtlessness -- risk-taking behaviors

www.medscape.com **(Mood change plus 3+ for 1 wk +)**

HYPOMANIA

- Elevated, expansive, or irritable mood, lasting ≥ 4 days, *plus*
- ≥ 3 symptoms of mania that
  - Are *not* severe enough to impair functioning markedly
  - Do *not* necessitate hospitalization
  - Are *not* accompanied by psychotic features
- Produces enough change to be noticed by others

American Psychiatric Association. *DSM-IV.* Washington, DC: APP;1994.

HYPOMANIA < 4 DAYS

- Duration criteria is ≥ 4 days
- Many people have hypomanic symptoms of sufficient severity but insufficient duration….such as 2 to 3 days
- Bipolar Disorder, Not Otherwise Specified

STRANGE BREW / John Deering
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DEERING
1-6
The representative from our Seattle office is here.

BIPOLAR DISORDER, DEPRESSED

- Distinct mood change **OR** loss of interest in things that used to give interest or pleasure PLUS
- Daily or near daily for at least 2 weeks PLUS
- A change in at least 4 out of these 7 baseline features:
  - Sleep; Appetite; Concentration; Energy; Guilt; (feelings of H/H/W); Suicidal thoughts; Psychomotor

BIPOLAR DISORDER, DEPRESSED

- AND causes significant distress or impairment in function at work or home or school
- AND is not due to another medical disorder (drug/alcohol, thyroid, meds, etc)
- AND episodes of hypomania or mania
  - Bipolar type I: mania; type II: hypomania
  - Major Depression: Neither mania nor hypomania

BIPOLAR DEPRESSION WHY IS IT HARD TO DX ?

- Hypomanic and manic episode may go unnoticed by the patient
  - > 50 % have depression as 1st episode
  - Most enjoy the hypomania, or there is great productivity so hard to see it as a "problem"
- Studies show ~ 75% of mood states in people with Bipolar Disorder are depressed

BIPOLAR DISORDER, MIXED

- Criteria met for both manic episode + major depressive episode for ≥1 week
- Symptoms
  - Are sufficient to impair functioning ***OR***
  - Necessitate hospitalization ***OR***
  - Are accompanied by psychotic features

American Psychiatric Association. *DSM-IV.* Washington, DC: APP;1994.

RAPID CYCLING

- 4 or more episodes of depression, mania or hypomania in previous 12 months
- Episodes are demarcated by a switch to the opposite polarity or by a period of remission
- Often triggered by antidepressants (esp. TCA though any antidepressant can do it)

American Psychiatric Association. *DSM-IV*. Washington, DC: APP;1994.

RAPID CYCLING

- 13 - 20% of all bipolar patients
- Initial onset 20%, later onset 80%
- Predominantly in females
- Associated with increased thyroid dysfunction

WHAT TO ASK

- Precipitant ?
  - (loss / threat of loss)
- Duration of episode
  - Longest ever
  - Shortest ever
  - Average
- Frequency/intensity
  - Tends to increase

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?

… thoughts raced through your head or you couldn't slow your mind down?

Mood Disorder Questionnaire

… you were so easily distracted by things around you that you had trouble concentrating or staying on track?

… you had much more energy than usual?

… you were much more active or did many more things than usual?

… you were much more social or outgoing than usual; for example, you telephoned friends in the middle of the night?

… you were much more interested in sex than usual?

… you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?

… spending money got you or your family into trouble?

MDQ NEGATIVE
(not Bipolar Disorder, type I)

- May represent :
  - Bipolar Disorder, type II or NOS
  - Cyclothymic Disorder
  - Other causes of mood swings
    - Metabolic; Structural lesions in brain; Infectious; medications (esp. Prednisone > 40 to 60 mg/d)
  - Substance-Induced Mood Disorder, cyclic

Manic Episode: Differential Diagnoses

Differential diagnosis	Consider if . . .
Mood disorder due to a general medical condition	• **Major medical condition present** • **First episode at >50 years of age**
Substance-induced mood disorder	• **Symptoms in context of intoxication or withdrawal** • **H/O treatment for depression**
Hypomanic episode	• **Mood disturbance not severe enough to require hospitalization or impair functioning**
Mixed episode	• **Manic episode and major depressive episode in 1 wk**

American Psychiatric Association. *DSM-IV.* Washington, DC: APP;1994.

Manic Episode: Differential Diagnoses

Differential diagnosis	Consider if . . .
ADHD	• **Early childhood mood disturbance onset** • **Chronic rather than episodic course** • **No clear onsets and offsets** • **No abnormally elevated mood** • **No psychotic features**

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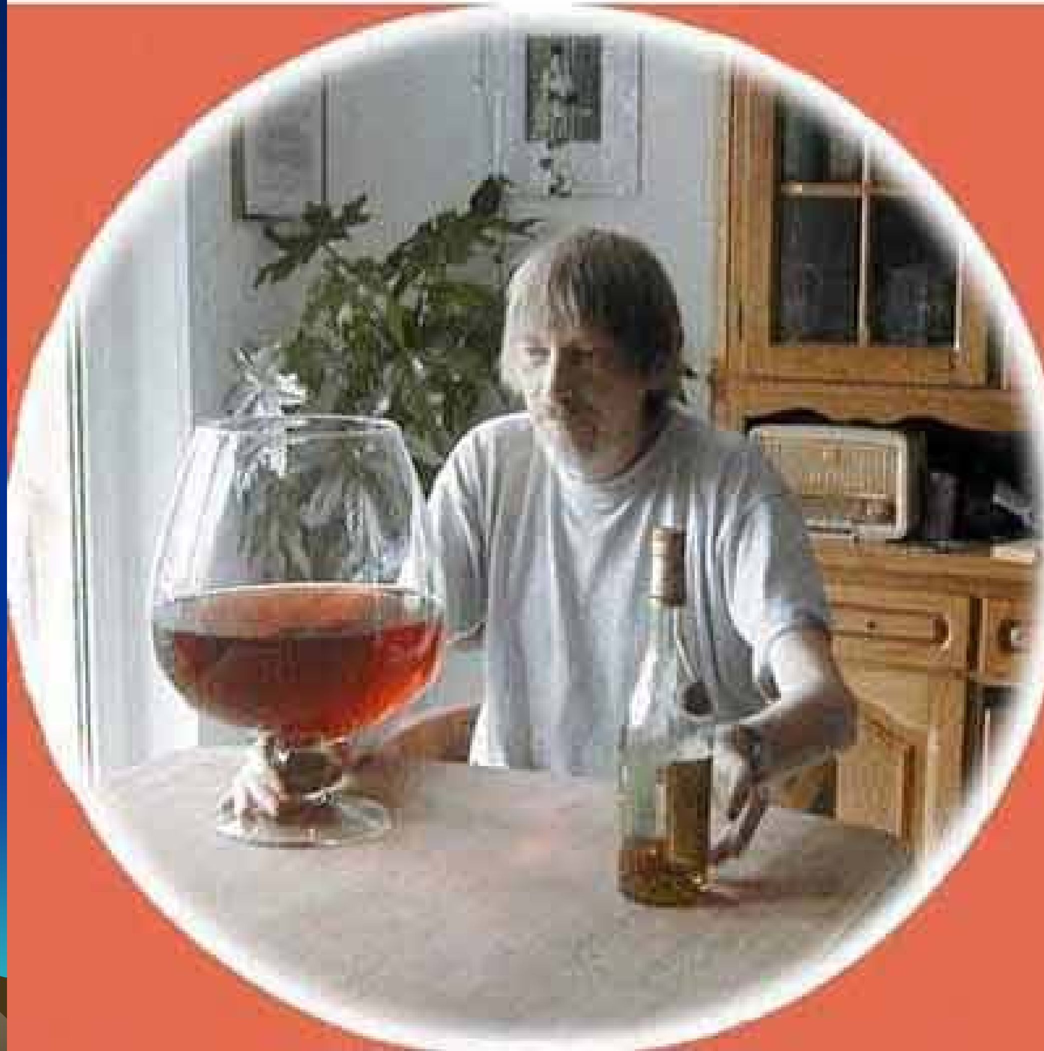
COMMONLY ABUSED DRUGS

- Alcohol
- Marijuana
- Opiates
- Cocaine, meth and other stimulants, including caffeine
- Cigarettes / Nicotine
- Benzodiazepines and barbiturates
- Hallucinogens
- Inhalants
- Rave drugs
- _______________

My Doctor said "Only 1 glass of alcohol a day". I can live with that.



WHAT IS ONE DRINK ?

- 12 grams of pure alcohol

  = one 12 oz beer

  = one wine cooler

  = one 5 oz glass wine

  = 1.5 ounces of distilled spirits
  (a jigger, vs. shot = 1 oz)

FUNNY BUSINESS
I DON'T MEAN TO OFFER SIMPLISTIC SOLUTIONS TO COMPLEX PROBLEMS, MR. HENROD...
8-4
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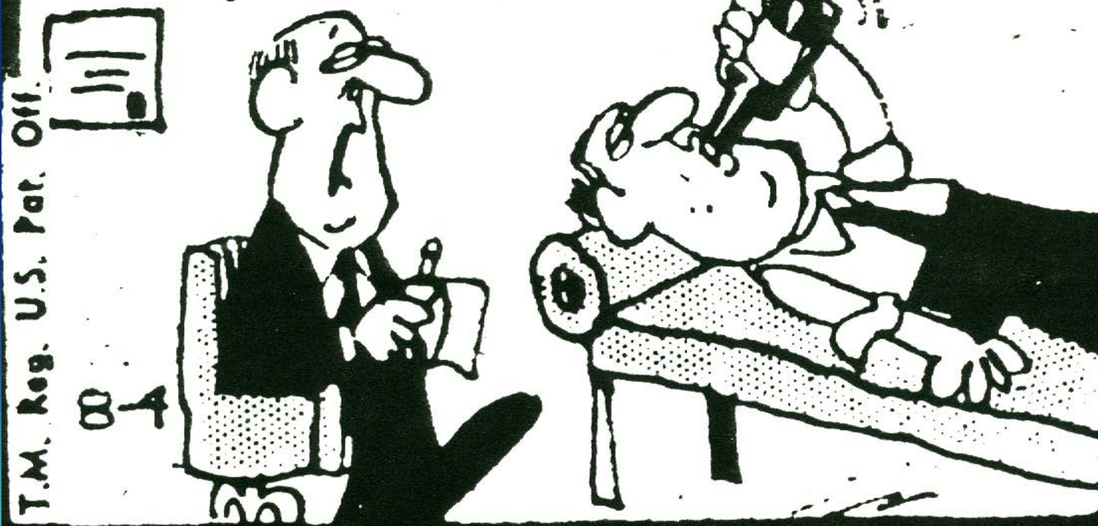

By Roger Bollen
... BUT, I THINK ALCOHOL IS PLAYING A LARGE ROLE IN CONTRIBUTING TO YOUR TROUBLES.
T.M. Reg. U.S. Pat. Off.
8-4

ALCOHOL / DRUG HISTORY

- Age 1st drink / use
  - Amount consumed / used
- Last intoxication w alcohol; last drug use
  - Amount able to “hold” w/o gross impairment
  - ? Increased tolerance
- Episodes of loss of control and what was done to contain or reduce future episodes
  - ? Success of control efforts ?

The WHOLE NORTHEAST was blacked out?
I thought it was just me again.
BIZARRO.COM

DRUGS AND ALCOHOL

- Anything that causes a problem, is a problem
  - If your alcohol or drug use causes you problems, then you have an alcohol and/or drug problem **PLUS** whatever problems the alcohol and/or drugs caused you

CHEMICAL DEPENDENCE

- 3 C ' s :
  - C ompulsive Use
  - Loss of C ontrol
  - C ontinued use despite adverse consequences

SUBSTANCE-INDUCED MOOD DISORDER

- Mood changes due to direct or indirect effects of drugs and/or alcohol in the brain
- Different from mood variability seen in the first several weeks to months of recovery from SUD
- Often requires medication and concurrent mental health tx and usual SUD tx

ABSTINENCE

- Staying “clean and sober” is no guarantee that problematic mood disruptions will go away
- Untreated problematic mood disruptions will undermine effective treatment of the SUD
- Cannot get full benefit of treatment of mood disorder if person continues to drink or use

(IDEAL) OBJECTIVE

- Differentiate:

  - Bipolar Disorder

    from

  - Substance-induced mood disorder, cyclic

    from

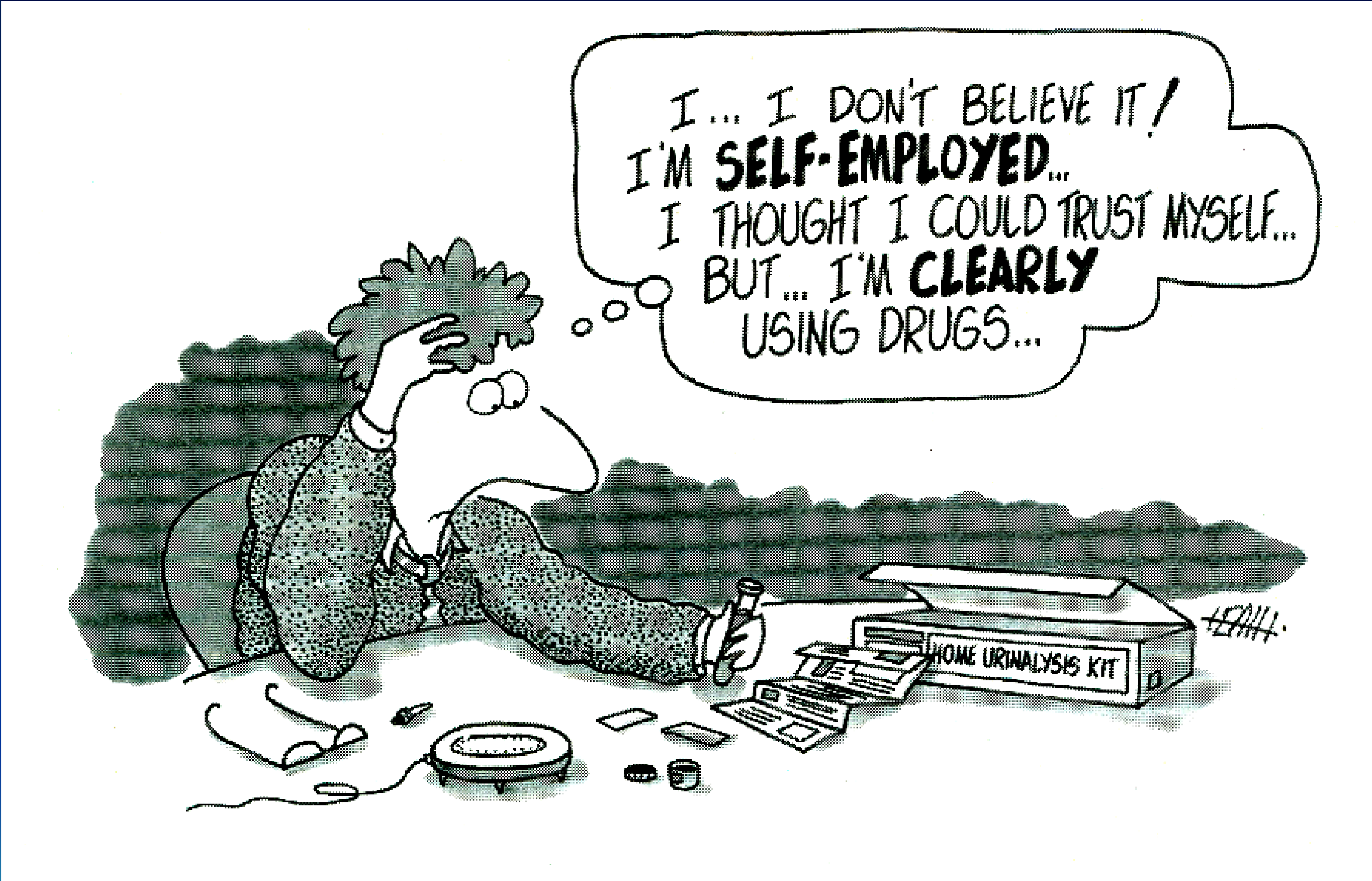
  - Mood swings of other etiologies

HAS BD AND SUD: NOW WHAT ?

- Is patient Safe ?
  - Assess risks:
    - Suicide; homicide; self-care; shelter; support
- Is patient Sane ?
    - Any impairing psychotic symptoms
- Is patient "Sober and clean ?"
    - Encourage / motivate ideal of abstinence
- Is patient Stable ?

REHAB CENTERS

CALLAHAN


I... I DON'T BELIEVE IT!
I'M SELF-EMPLOYED...
I THOUGHT I COULD TRUST MYSELF...
BUT... I'M CLEARLY
USING DRUGS...
HOME URINALYSIS KIT

Practicing Safe Sex at the Olympics

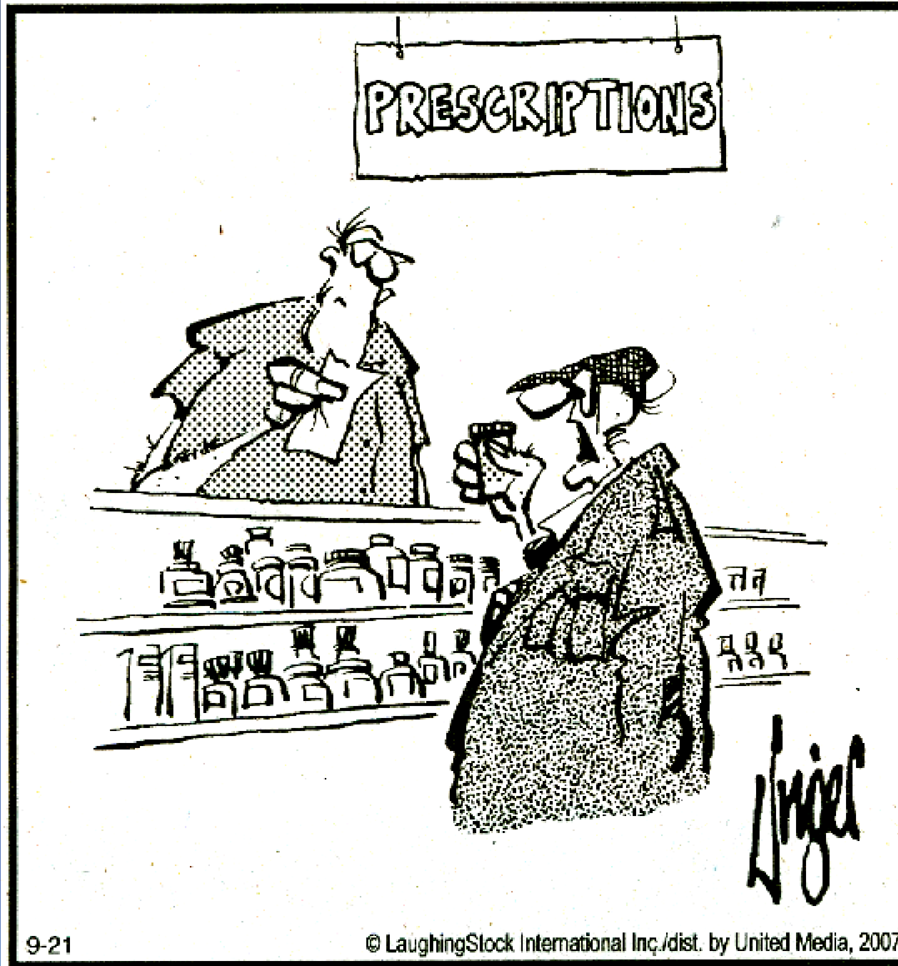
TREAT IMPAIRING SYMPTOMS

- Mood stabilizing medication
- Antipsychotic medication
  - Atypical vs. Conventional
- Combination

TX CONSIDERATIONS

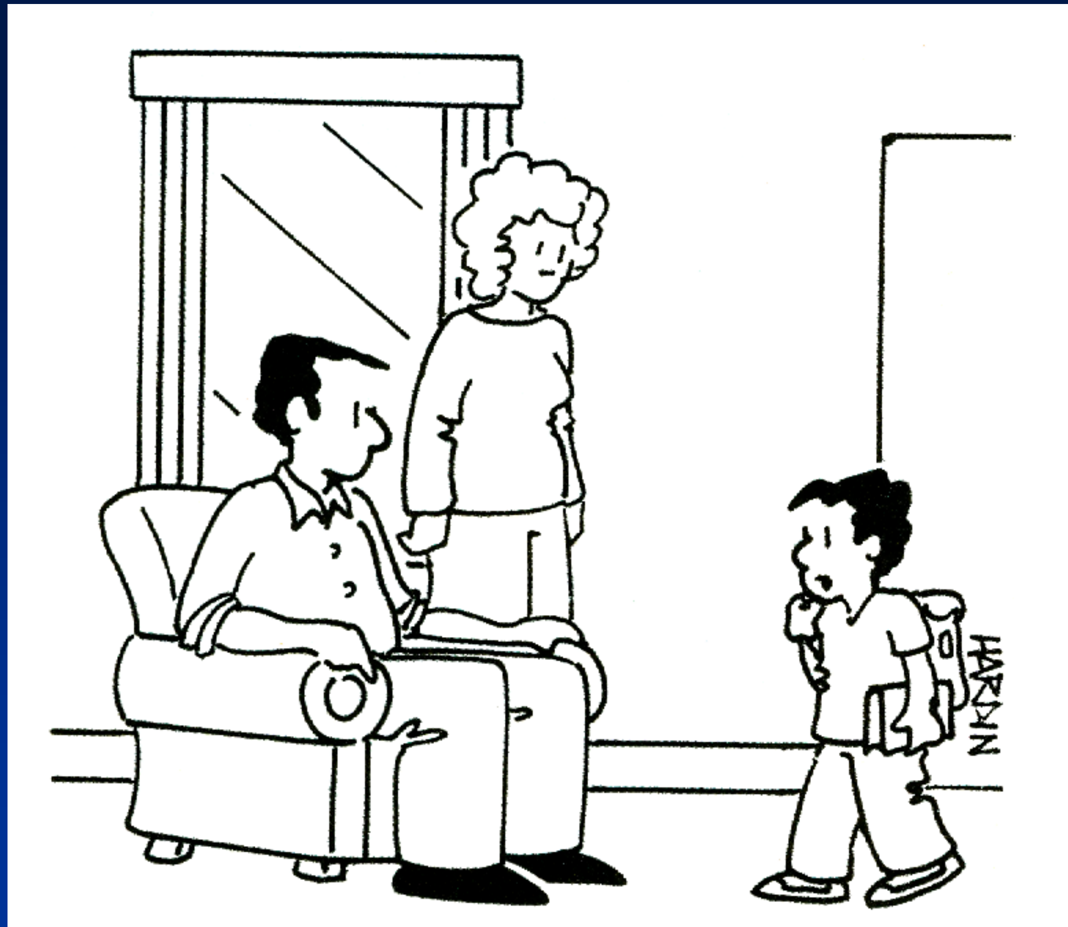
- Psychiatric features
  - psychotic; suicide, homicide, and violence
- Demographic & psychosocial factors
  - gender, cross-cultural issues, geriatric patients
- Concurrent medical conditions
  - HIV infection, other medical

Hirschfeld RMA et al. Am Journal of Psychiatry 2002;159(4):1-50.



"Are there any side-effects to these besides bankruptcy ?"

"I only smoke now so that I can sue someone for it later."



“Boy, what a depressing day. We studied hereditary.”

MOOD STABILIZERS

- Lithium *
- Divalproex *
- Lamotrigine *
- Equetro * (Carbamazepine ER)

* FDA-approved for use in Mania for Bipolar Disorder

(why this is important: Liability risk and "off-label" term used more and more by HIPs to deny coverage)

MOOD STABILIZERS

- Lithium carbonate
  - Eskalith, Lithobid, Lithium
- Divalproex
  - Depakote ER, Valproic acid
- Carbamazepine
  - Tegretol, Carbatrol ER
  - Equetra
- Oxcarbazepine
  - Trileptal

MOOD STABILIZERS

- Neurontin
  - Gabapentin
- Lamotrigine
  - Lamictal
- Topiramate
  - Topamax
- Tiagibine
  - Gabatril

MOOD STABILIZERS

- Keppra
  - Levetiracetam
- Zonegran
  - Zonisamide
- Newer ones

ATYPICAL ANTIPSYCHOTICS

- Clozaril (Clozapine)
- Risperidone (Risperdal)
- Quetiapine (Seroquel)
- Olanzapine (Zyprexa)
- Ziprasidone (Geodon)
- Aripiprazole (Abilify)
- Invega (Paliperidone)

CONVENTIONAL ANTIPSYCHOTICS

- Haldol (Haloperidol)
- Stelazine (Trifluoperazine)
- Thorazine (Chlorpromazine)
- Mellaril (Thioridazine)
- Trilafon (Perphenazine)
- Navane (Thiothixene)
- Prolixin ( )

ACUTE MANIA

- With or without psychosis: Meds of choice:

Lithium OR Divalproex

+

Risperidone OR Olanzapine

ARE BETTER THAN ANY ONE ALONE

MEDICATION COMBINATIONS

- Combinations often needed to achieve symptom control, if not remission, and to prevent future episodes
- Each additional medication increases risk of side - effects and/or med interactions

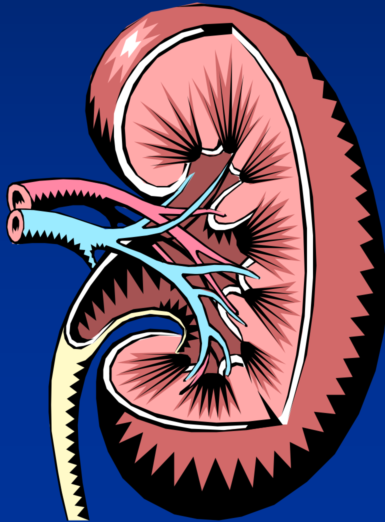
Hirschfeld RMA et al. Am Journal of Psychiatry 2002;159(4):1-50

LITHIUM

- Lithium still effective after 50+ years
- Ability to tolerate Lithium is greater during acute mania and then decreases
- Start dose: 300 mg TID or once daily
- Serum lithium level:
  - 10 to 14 hours post-last dose
  - Q 4 - 7 days until level and clinical condition stable or until side-effects preclude higher dose

Fieve R, Adler L, Allen M, et al. Lithium as a mood stabilizer: 50+ years later. Poster presented at: Annual Meeting of the American Psychiatric Association; May 18-23; Philadelphia, Pa.

LITHIUM SIDE-EFFECTS



- Relative Contraindications:
  - Heart or kidney dis.
  - Diuretic use
  - NSAID use
    - Inc. Lithium levels 40 + %
  - Chronic diarrhea
    - Li caps vs. tabs
  - Psoriasis / acne

LITHIUM SIDE-EFFECTS

- Hand tremors
- Urinary frequency
- GI (nausea, diarrhea)
- Metallic taste
- Weight gain
  - 20 to 25 % gain weight, often > 15 lbs

ANTICONVULSANTS

- Except Lithium, all other mood stabilizing medications are anticonvulsants with shared side-effect risks:
  - Sedation, fatigue
  - Blurred / double vision
  - Balance problems, clumsy, falls
  - Cognition fuzziness, forgetfulness
- These can occur in therapeutic doses, too

DIVAPROEX (Valproic acid)

- Loading dose for middle aged folks:
  - 30 mg/kg body wt for 2 days, then
  - 20 mg/kg body wt
- Effective serum Depakene levels achieved in 3 days and well-tolerated

Keck, Allen et al. *Safety and Efficacy of Rapid-Loading Divalproex Sodium in Acutely Manic Bipolar Patients.* 1999, Poster Session 152nd Meeting APA

DIVAPROEX (Valproic acid)

- Alternate strategy:

Take patient's weight in lbs, add "zero," and it converts to oral dose mg/day

DIVALPROEX

- Divalproex
  - Peak onset 2 hours, half-life 10 hours
  - TID, sometimes BID dosing
- Depakote ER
  - Peak onset 5 hours; HL 9 to 16 hours but slow release is over 18 to 24 hours, so once daily dosing, AM or HS; steady state 3 days
  - More consistent efficacy through the day
  - Less side-effects (less peak and trough)

EQUETRO (CARBAMAZEPINE ER)

- Acute mania: 200 mg BID for 3 to 7 days, then 400 mg BID
  - Serum Tegretol levels not recommended
- Average effective dose 700 mg daily
- 100, 200, and 300 mg caps
  - Can be pulled apart and sprinkled on food
- Pre-treatment CBC w plts, AST
- Many med interactions

LAMOTRIGINE

- Dosing to minimize risk of skin rash
  - Weeks 1 - 2 25 mg QD
  - Weeks 3 - 4 50 mg QD
  - Week 5 100 mg QD
  - After week 5: increase by 100 mg/wk, up to 300 mg/day if clinically indicated
- Not for acute mania

Calabrese JR, et al. J Clin Psychiatry 2000; 61: 841-50.

LAMOTRIGINE

- Metabolized mostly by glucuronic acid conjugaton, so: medication interactions:
  - Doubles Lamotrigine levels by ↓ clearance:
    - Divalproex (Depakote ER; Valproic acid)
  - Halves Lamotrigine levels by ↑ clearance:
    - Carbamazepine (Tegretol); Dilantin (Phenytoin); Phenobarbital (Phenobarb); Primidone (Mysoline)

LAMOTRIGINE

- Increases Lamotrigine blood levels:
  - BCPs ; no effect on contraception
- No impact on Lamotrigine levels:
  - Lithium (and no impact on Lithium level)
  - Trileptal (Oxcarbazepine)
  - Keppra (Levetiracetam)

LAMOTRIGINE

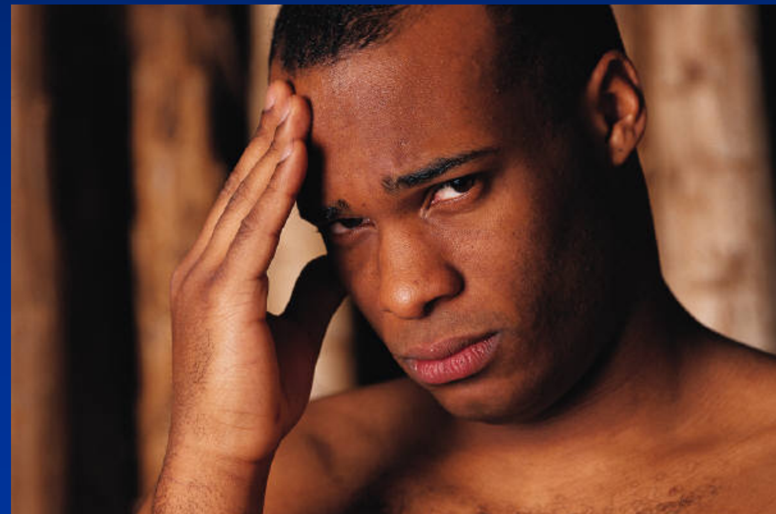
- Risk of rash: same as any med when dosing protocol is followed
- See Doctor ASAP if following occur:
  - Skin rash w/wo hives
  - Fever
  - Swollen glands in neck
  - Painful sores in mouth or around eyes
  - Swelling of lips or tongue

NEURONTIN

- Not effective in Bipolar Disorder when used as sole mood-stabilizer
- Effective as add-on
- No medication interactions
- Kidney metabolism

NEURONTIN

- Indications:
  - Inadequate mood stability with 1st mood stabilizer
  - Significant anxiety component
  - No medication interactions



NEURONTIN

- Caps: 100 mg, 300 mg, 400 mg
- Tabs (generic): 400 mg, 600 mg, 800 mg
- Peaks in 2 hours; ½ life 10 hours
  - Can be used prn acute anxiety or breakthrough mood reactivity
- Starting dose: 300 mg TID or more aggressive depending on acuity/severity

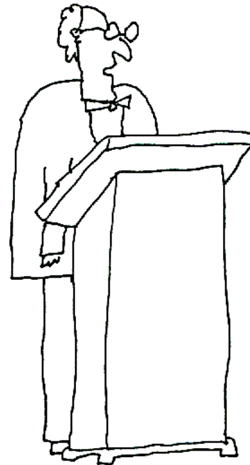
NON-MED TX OPTIONS

- Omega-3-fatty acid
- Psychotherapy “here and now” initially
- Exercise / Sleep
- Phototherapy
- ECT

RECOVERY PSYCHOTHERAPY

- Individual therapy
- Couples counseling
- Family therapy
- Group therapy
- Combination med / therapy group

A.A. IN L.A.



CALLAHAN

"My name is Mort and I represent Chuck who's an alcoholic."

NON-AA MUTUAL SELF-HELP GROUPS

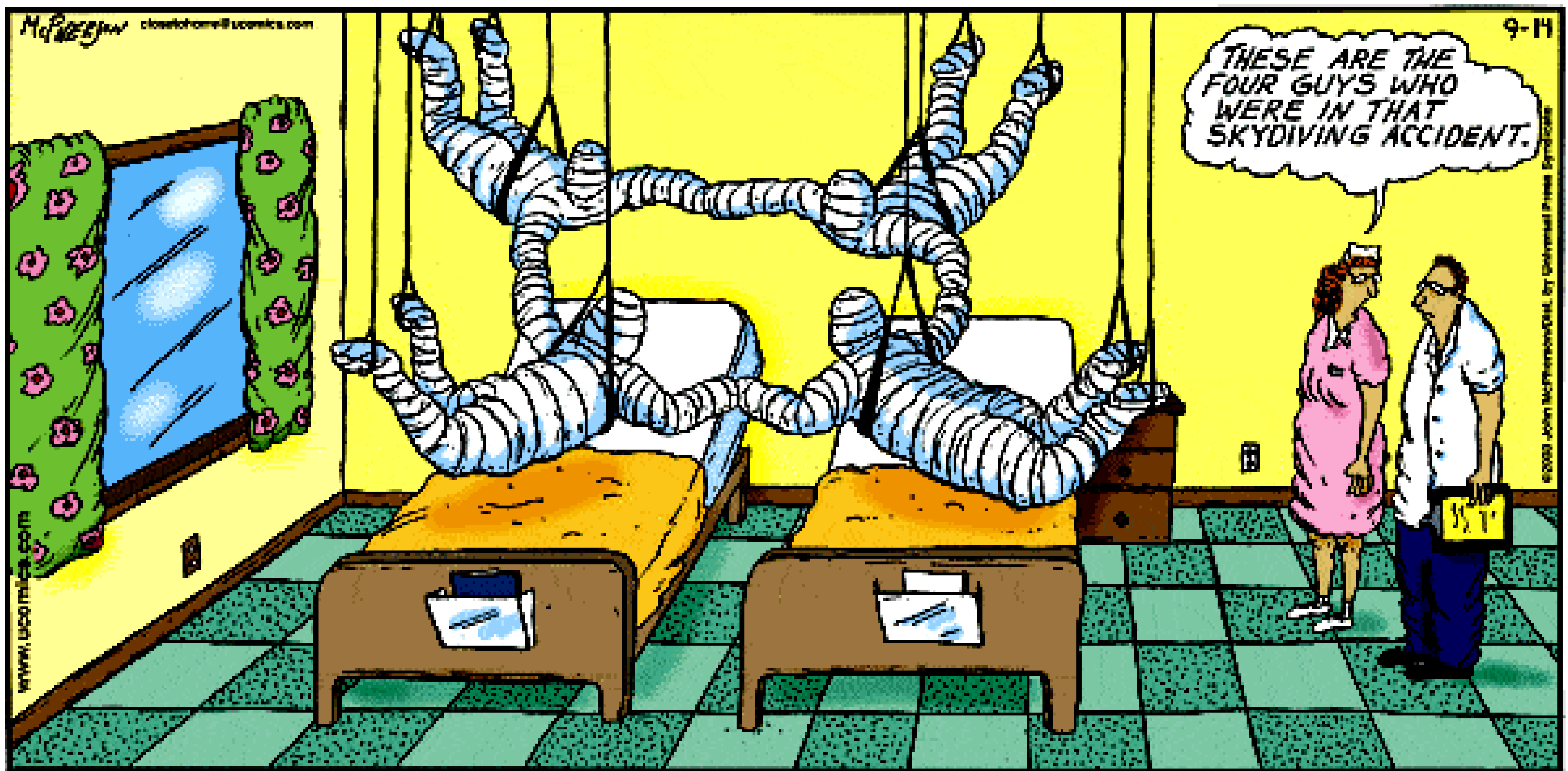
- Dual Recovery Anonymous (DRA)
- Sobriety Knowledge Is Power (SKIP)
- Women For Sobriety (WFS)
- Self-Management Alcohol Recovery Training (SMART)
- Rational Sobriety (RR)
- Lifering Secular Recovery
- ____________________

SUMMARY

- Careful initial evaluation
  - Screen all depressed pts for Bipolar Disorder
- History from others
  - Family, friends, etc.
  - Other members of treatment team
    - CDC, therapist, primary care provider, specialists
- Encourage "clean and sober"

SUMMARY

- Treat impairing symptoms first
- Serial, frequent assessments
- Adjust treatment as indicated
- Motivate "clean and sober"
- Collaborate and consult
- Repeat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Daniel E. Wolf, D.O.

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- American Society of Addiction Medicine, 1989