Primary Care Perspectives on Treating Bipolar Disorder: A Cross-Sectional Survey

Randy A. Sansone, MD; Jeremy S. Forbis, PhD; and Tres Sosa, MD

Objective: In this study, we explored the comfort level of and influences upon primary care clinicians in prescribing psychotropic medications to patients with bipolar disorder.

Method: In May 2010, we mailed a 1-page survey to a cross-sectional sample of 143 primary care clinicians in 2 large practice groups asking physicians to specify whether they prescribe psychotropic medications to bipolar patients, describe their comfort level in prescribing psychotropic medications to this patient group, indicate possible influences on their willingness to prescribe psychotropics for bipolar patients, and provide their opinion on whether or not primary care physicians should prescribe these medications to bipolar patients.

Results: Of the 38 respondents (response rate of 26.6%), nearly two-thirds (n = 24) reported the prescription of psychotropic medications to bipolar patients in their practices. For questions related to bipolar diagnosis and treatment, the means of all responses trended toward uncomfortable, with the prescription of antipsychotics being indicated as the aspect with which respondents were least comfortable. As for factors influencing a decision to prescribe, the restricted availability of mental health services was rated as most influential. With regard to the perceived role of primary care clinicians in prescribing psychotropic medications to bipolar patients, no respondent indicated that primary care physicians should "always" prescribe, whereas approximately two-thirds indicated "rarely" or "on occasion."

Conclusions: While a majority of primary care clinicians prescribe psychotropic medications to patients with bipolar disorder, a majority are also understandably hesitant to do so and appear to do so in particular circumstances, most likely related to the restricted availability of mental health services.

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Corresponding author: *Randy A. Sansone, MD, Sycamore Primary Care Center, 2115 Leiter Rd, Miamisburg, OH 45342 (Randy.sansone@khnetwork.org).*

According to the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision,[1] the prevalence of bipolar disorder in the general US population is approximately 1.3%–1.6%. Despite the low frequency of this Axis I dysfunction, bipolar disorder can be extremely challenging to treat in primary care settings for a number of reasons. First, early episodes may be depressive in nature, resulting in initial underrecognition of the disorder. With misdiagnosis and possible treatment with antidepressants alone, the course of illness may be complicated by antidepressant-induced switches to manic episodes and/or rapid cycling.

Second, patients with bipolar disorder are characterized by high frequencies of comorbid psychiatric disorders, particularly substance use, anxiety, impulse-control, eating, and attention-deficit/hyperactivity disorders, resulting in multiple layers of psychiatric complexity.[2] When present, these comorbid psychiatric disorders may require additional as well as specialized treatment (eg, for substance abuse or eating disorders), which may not be readily accessible in primary care settings.

Third, individuals with bipolar disorder have a relatively high risk of suicide attempts/completions. To underscore this risk, according to Pompili and colleagues,[3] the rate of suicide *completion* in those with bipolar disorder is 20-fold higher than in the general population. Suicidal ideation/attempts are clearly a challenging issue to manage in primary care settings.

Fourth, the pharmacologic treatment of bipolar disorder is interspersed with continuing controversies, including the role of antidepressants,[4,5] variable evidence regarding which anticonvulsants are genuinely effective,[6] and the burden/benefit ratio (eg, a number of indicated medications may cause substantial weight gain[7] and thereby contribute to the development of metabolic syndrome[8]). In addition, pharmacologic treatment is frequently encumbered by routine laboratory studies (eg, lithium, several anticonvulsants, atypical antipsychotics) and serum drug levels (eg, lithium, several anticonvulsants), which require supplementary financial outlays by the patient. In summary, for a number of reasons, patients with bipolar disorder are challenging to diagnose and treat, especially in primary care settings.

However, because many patients have difficulty accessing specialized psychiatric treatment, individuals with bipolar disorder are increasingly being evaluated and treated in primary care settings. Yet, the diagnosis

Clinical Points

- While the majority of primary care clinicians in this study reported prescribing psychotropic medications to patients with bipolar disorder, two-thirds endorsed such prescription only "rarely" or "on occasion."
- Among the various psychotropic medications available, participants indicated that they were least comfortable with prescribing antipsychotics to bipolar patients.
- One factor that appears to drive psychotropic medication prescription for bipolar patients in primary care settings is the restricted availability of mental health services.

and management of bipolar disorder in these settings may be relatively more daunting than other psychiatric disorders. To underscore these potential diagnostic and management difficulties, Frye and colleagues[9] found that 78% of primary care physicians failed to detect or misdiagnosed bipolar disorder. Hirschfeld and colleagues[10] examined primary care patients who were being treated for depression alone and found that 21.3% screened positively for bipolar disorder on a self-report measure; on the basis of semistructured interview data of a subsample, the estimated prevalence of bipolar disorder in this cohort was 27.9%. According to Hajek and colleagues,[11] even among patients with 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. With regard to the pharmacologic management of bipolar disorder, Stang and colleagues[12] examined the knowledge base of primary care physicians and found that *no* participants correctly identified all of the medications that are approved by the US Food and Drug Administration for the treatment of this disorder. To summarize, the treatment of bipolar disorder in primary care settings can be "difficult and time-consuming."[12] This conclusion invites the question under investigation in this study—are primary care clinicians professionally comfortable in diagnosing and treating patients with bipolar disorder?

According to the findings of the only relevant empirical study that we could locate, which was published in 1987,[13] 74.3% of primary care physicians rated their ability to treat bipolar patients as "low." However, according to a 2004 article,[14] some primary care physicians clearly advocate the treatment of bipolar disorder in primary care settings. Given this disparity, in a contemporary sample of primary care clinicians, we examined participants' professional comfort level in treating patients with bipolar disorder as well as the influences affecting a decision to treat.

METHOD

Participants

Potential participants were male and female primary care clinicians, predominantly family medicine physicians but also physician's assistants and nurse practitioners, in 2 practice groups in a midsized midwestern city. Both practice groups have office sites that are dispersed throughout the city. To participate in this study, primary care clinicians had to be in active medical practice and not retired. The practice groups comprised 143 individuals; 38 respondents returned surveys, for a response rate of 26.6%.

The age of the sample ranged from 30 to 75 years, with a mean age of 47.8 years (SD = 10.75). Years in practice ranged from 1 to 47 years (mean = 17.37, SD = 11.54). The remaining demographic characteristics of the sample are shown in Table 1.

Procedure

After contacting the clinical administrator for each practice group, we obtained site permissions and potential participants' mailing addresses. In May 2010, each potential participant was mailed a 1-page survey with an enclosed, addressed, metered return envelope. Mailings were undertaken only once (no reminders or follow-up mailings/telephone calls were undertaken).

As for the survey content, we initially explored demographic data (eg, age, sex, race, type of training background, years in practice, type of practice setting). We then asked respondents if they prescribed psychotropic medications to bipolar patients. Using a 5-point Likert-type response scale (1 = very comfortable, 2 = comfortable, 3 = neutral, 4 = uncomfortable, 5 = very uncomfortable), we next explored participants' comfort level with regard to 5 aspects of bipolar disorder diagnosis and treatment (eg, in-office diagnosis of bipolar disorder, use of lithium in bipolar disorder). Next, using a 5-point Likert-type response scale (1 = not at all, 2 = very little, 3 = somewhat, 4 = a lot, 5 = extremely), we explored potential influences on participants' willingness to prescribe medications to patients with bipolar disorder (eg, controversies over antidepressant use, psychiatric comorbidity, suicide risk).

Table 1. Demographic Characteristics of the Study Sample and Comparisons Between Clinicians Who Do Versus Do Not Prescribe Psychotropic Medications to Patients With Bipolar Disorder

Demographic Variable	n[a]	%	Currently Prescribe Psychotropic Medication, n (%)[b] Yes	No
Sex				
Male	26	68.4	18 (72.0)	7 (28.0)
Female	12	31.6	6 (50.0)	6 (50.0)
Race				
White	34	89.5	21 (63.6)	12 (36.4)
Asian	3	7.9	2 (66.7)	1 (33.3)
Other	1	2.6	1 (100.0)	0 (0.0)
Training				
MD	33	68.8	21 (65.6)	11 (34.4)
DO	4	10.5	3 (75.0)	1 (25.0)
NP	1	2.6	0 (0.0)	1 (100.0)
Practice setting				
Urban	7	18.4	6 (85.7)	1 (14.3)
Suburban	26	68.4	14 (56.0)	11 (44.0)
Rural	5	13.2	4 (80.0)	1 (20.0)

[a]N = 38 except as indicated.
[b]N = 37; there were no statistically significant differences between prescribers and nonprescribers with regard to the above demographic variables or age of the practitioner.
Abbreviations: DO = doctor of osteopathy, MD = medical doctor, NP = nurse practitioner.

Table 2. Response Patterns of Primary Care Clinicians to Queries About Comfort Level, Influencing Factors, and Medication Prescription to Bipolar Patients

Query	Responders, n	Item Score Mean	SD
Comfort level in practice with…[a]			
Diagnosis of bipolar disorder	38	3.18	1.22
Lithium prescription	38	3.39	1.12
Anticonvulsant prescription	38	3.05	1.22
Typical antipsychotic prescription	38	3.52	1.08
Atypical antipsychotic prescription	38	3.50	1.20
Factors that influence willingness to prescribe psychotropic medications to bipolar patients[b]			
Controversies over antidepressant use	37	2.78	1.03
Controversies over anticonvulsant use	37	2.83	1.06
Psychiatric comorbidity	37	3.54	1.04
Suicide risk	37	3.45	1.04
Potential legal liability	37	3.29	1.05
Restricted availability of mental health services	37	4.16	0.89
Patient's financial inaccessibility to health care	37	3.70	1.05
Should primary care clinicians prescribe psychotropic medications to bipolar patients[c]	38	2.81	0.72

[a]1 = very comfortable, 2 = comfortable, 3 = neutral, 4 = uncomfortable, 5 = very uncomfortable.
[b]1 = not at all, 2 = very little, 3 = somewhat, 4 = a lot, 5 = extremely.
[c] 1 = always, 2 = generally, 3 = on occasion, 4 = rarely.

Finally, we queried participants about whether primary care clinicians should prescribe medications to patients with bipolar disorder and provided a space for comments.

This project was approved by the institutional review board of the local university. Completion of the survey was assumed to be informed consent, which was clarified for participants in the survey materials.

RESULTS

The findings of this study are summarized in Tables 1 and 2. Approximately two-thirds of participants reported the prescription of psychotropic medications to patients with bipolar disorder (see Table 1). There were no demographic differences between prescribers and nonprescribers. All responses to comfort levels with treatment strategies leaned toward the negative. Overall, respondents were *least* comfortable in prescribing antipsychotics to patients. With regard to prescribing influences, the restricted availability of mental health services was the most influential factor affecting respondents' willingness to prescribe psychotropic medications (see Table 2). Finally, no respondent supported "always" prescribing psychotropic medications to bipolar patients; the largest proportion (n = 17; 44%) indicated "on occasion," followed by "generally" (n = 14; 36.8%) and "rarely" (n = 7; 18.4%).

In addition to the preceding findings, 15 respondents (39.5%) provided comments at the bottom of their surveys. On some surveys, there were multiple comments. To summarize these, 7 respondents expressed concerns about accurately diagnosing bipolar disorder; 5 described feeling unfamiliar with the prescribed medications or were concerned about medication side effects; 4 believed that the diagnosis and treatment of bipolar disorder were beyond their scope of practice; 3 identified a lack of psychiatric backup in the community; 1 described treatment recommendations as "inconsistent"; 1 believed that some patients use primary care services to avoid psychiatric treatment; and 1 expressed concern about the potential legal implications in treating bipolar patients. One practitioner indicated that, following accurate diagnosis by a psychiatrist and stabilization on psychotropic medications, continuing treatment in a primary care setting could be successfully undertaken. Another respondent commented that, "Noncompliance is high with proposed mood stabilizers…many desire only benzodiazepines…thus, [there is a] high probability of relapse/insufficient control of symptoms."

DISCUSSION

To summarize these findings, 63.2% (nearly two-thirds) of participants reported the prescription of psychotropic medications to bipolar patients in their practice. In terms of comfort level with diagnosis and the prescription of medications, the mean for all items trended toward uncomfortable, with mild discomfort with anticonvulsant prescription and the diagnosis of

bipolar disorder, somewhat greater discomfort with lithium prescription, and the greatest discomfort with the prescription of antipsychotics, either typical or atypical. As for factors influencing the prescription of psychotropic medications to bipolar patients, of most concern was the restricted availability of mental health services, followed by the patient's financial inaccessibility to mental health care, psychiatric comorbidity, suicide risk, and potential legal liability. Should primary care clinicians prescribe psychotropic medications to bipolar patients in their practices? In the opinion of these respondents, nearly two-thirds indicated "rarely" or "on occasion."

The limitations of this study include the small sample size; low response rate, which is not atypical for one-time survey mailings; and the self-report nature of the data. (Of note, the low response rate could affect the validity of findings.) However, these findings provide an initial glimpse at some of the issues experienced by primary care clinicians as they wrestle with the diagnosis of bipolar disorder and prescription of psychotropic medications to their patients with this disorder. There appear to be numerous areas of discomfort as well as various psychosocial influences that temper prescription patterns.

Drug name: lithium (Lithobid and others).

Author affiliations: Departments of Psychiatry and Internal Medicine, Wright State University School of Medicine, Dayton, and Department of Psychiatry Education, Kettering Medical Center, Kettering (Dr Sansone); Department of Sociology, University of Dayton, Dayton (Dr Forbis); and Department of Internal Medicine, Kettering Medical Center, Kettering (Dr Sosa), Ohio.

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