# What To Do When Someone Screens Positive For Hypomania

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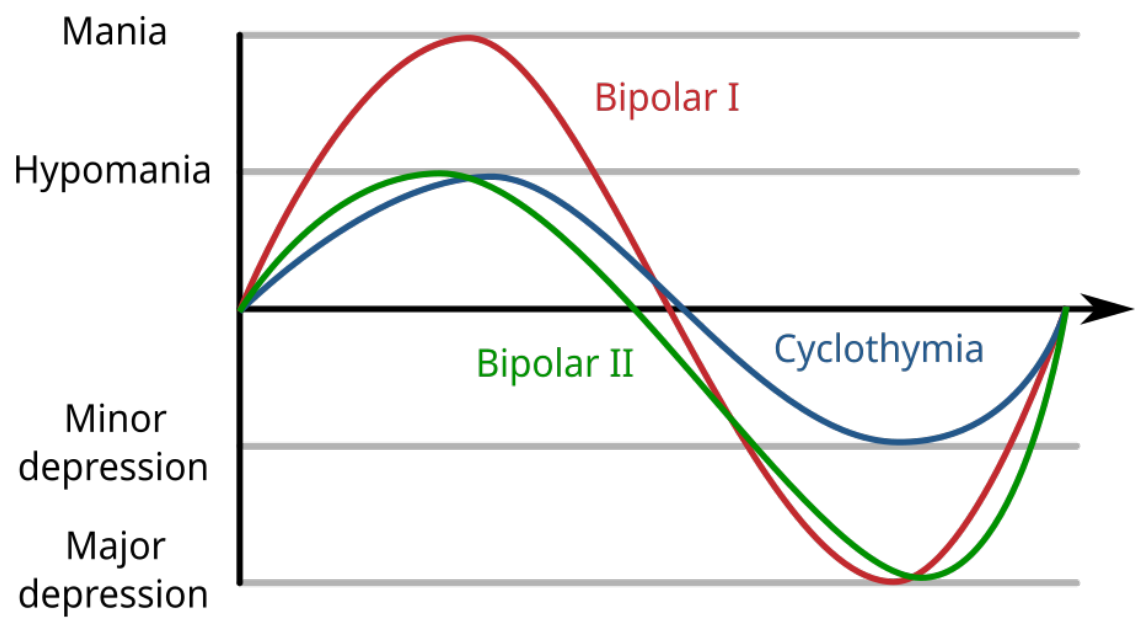
# Goals for today

- Recognize the importance of screening for hypomania in the perinatal period.
- Identify a validated screening tool for hypomania.
- Outline the immediate next steps after a positive hypomania screen.
- Describe the key elements of an Access consultation for a positive hypomania screen.

# What is Hypomania? A Refresher

- Does not just occur in bipolar II disorder
- Patients generally present for care in the depressed state
- Difficult to diagnose with SUD present, or in adolescents/early adulthood
- Mean age of onset is 20-30 years for women




*Risk Factors for Relapse or Recurrence in Women With Bipolar Disorder and Recurrent Major Depressive Disorder in the Perinatal Period: A Systematic Review.* *Alcantarilla L, López-Castro M, Betriu M, et al.*
*Archives of Women's Mental Health. 2023;26(6):737-754. doi:10.1007/s00737-023-01370-9.*



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# What is Hypomania? A Refresher

- Abnormally and persistently elevated, expansive, or irritable mood and abnormally or persistently increased goal-directed activity.
- Lasts at least **4 consecutive days**, most of the day, nearly every day.
- 3 or more of the following; 4 if irritable mood:
  - Inflated self esteem or grandiosity
  - Decreased need for sleep
  - More talkative than usual
  - Flight of ideas or racing thoughts
  - Distractibility
  - Increase in goal-directed activity or psychomotor agitation
  - Activities with painful consequences
- **No psychosis**, not severe enough to cause marked impairment or hospitalization.
- Unequivocal change in functioning that is observable by others
- Not due to substance or other medical condition

*Citation: American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.).*

# What Hypomania is not

- It does not typically feature:
  - Psychosis or require hospitalization (automatically mania)
  - Months or weekslong duration (likely a mixed episode)
  - Situation-dependent mood swings on the order of seconds to hours (likely borderline traits)
  - Normal joy and euphoria (not functionally impairing)

*Citation: American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.).*

# Hypomania in the perinatal period

- A wide range of women will experience hypomanic symptoms in the first week after childbirth (between 9 and 49%)
- This appears to mostly be transient and analogous to the “baby blues”
- However, this then increases the risk that a mom will “convert” to bipolar II disorder by 11-18x
  - Rates of conversion in some studies is 6.5%
- Risk factors include
  - Family history of bipolar disorder
  - Poor sleep
  - Lower social support

Sharma V, Xie B, Campbell MK, Penava D, Hampson E, Mazmanian D, Pope CJ. A prospective study of diagnostic conversion of major depressive disorder to bipolar disorder in pregnancy and postpartum. Bipolar Disord. 2014 Feb;16(1):16-21. doi: 10.1111/bdi.12140. Epub 2013 Oct 16. PMID: 24127853.

# The Stakes: Why Screen for Hypomania in Pregnancy?



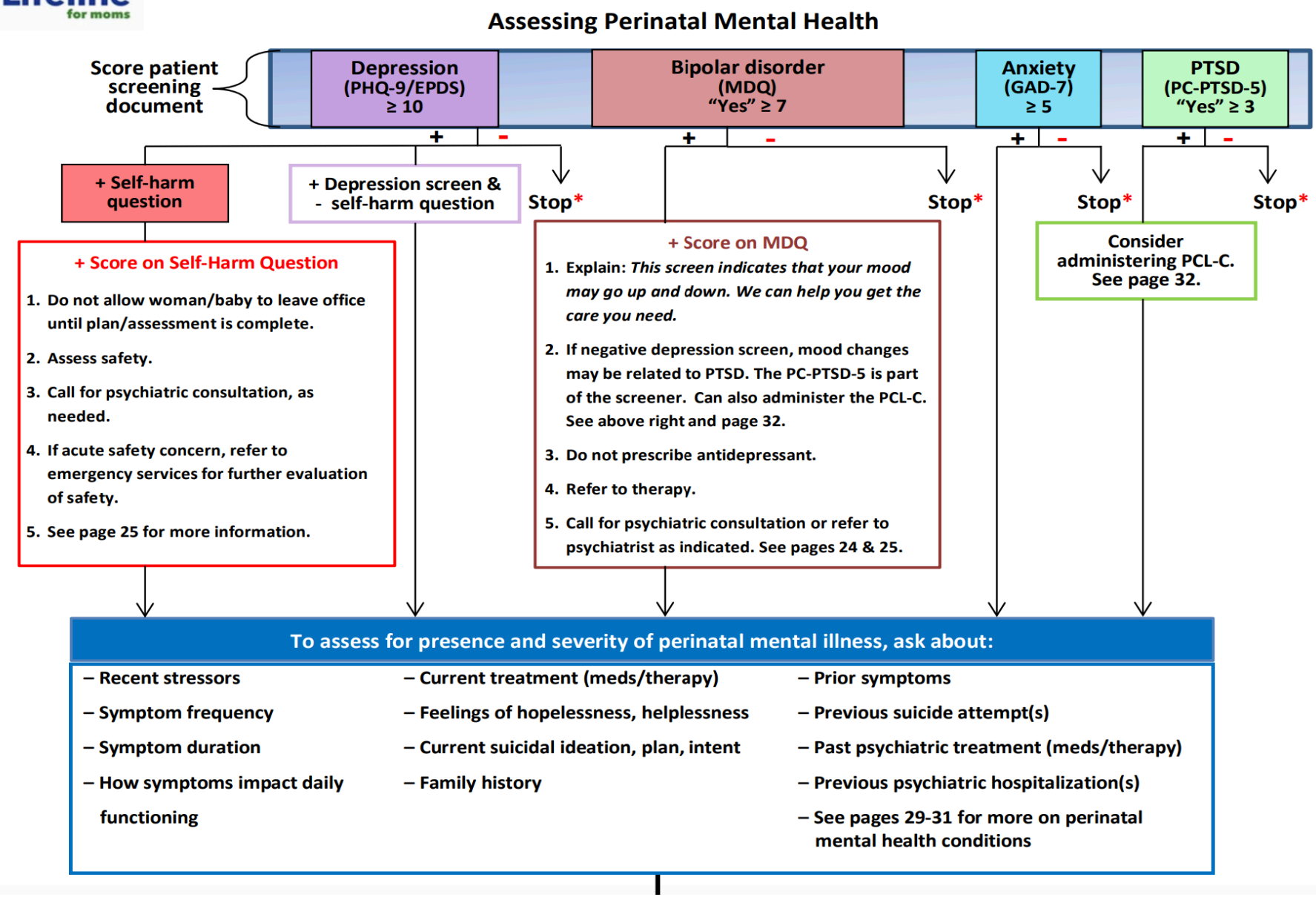
- Increased risk of bipolar disorder onset/recurrence in perinatal period
- ~20% of patients with a positive perinatal depression screen may have bipolar disorder instead
- Bipolar disorder is associated with increased increased risk of postpartum psychosis and postpartum psychosis is associated with suicide and infanticide
- **Treating with an unopposed antidepressant can induce mania**, mixed states, and rapid cycling, all of which carry significant risks.
  - Risk of antidepressant-associated hypomania or mania is ~7-14%
  - For patients at risk for bipolar I disorder, "switch" occurs in 17-49% of the population
  - Women are at higher risk for this

*American College of Obstetricians and Gynecologists. (2023). Screening and Diagnosis of Mental Health Conditions During Pregnancy and Postpartum. ACOG Clinical Practice Guideline No. 4.*

*Lifeline 4 Moms Perinatal Mental Health Toolkit (2022).*

# Screening for Perinatal Disorders

Lifeline for moms



# When to suspect hypomania

**How is bipolar disorder different from depression?**

| Depression | Bipolar disorder |
|---|---|
| - Depressive episodes | - Depressive episodes AND manic (Type I) or hypomanic (Type II) episodes |
| - No mania or hypomania | - Mood stabilizers or antipsychotics can be used to stabilize mood |
| - Medication treatment = antidepressant | |

**Consider bipolar disorder if any of the following are present:**

- Patient reports a history of bipolar disorder
- MDQ is positive
- Patient is taking medication for bipolar disorder (e.g., mood stabilizer or antipsychotic)

*Lifeline 4 Moms Perinatal Mental Health Toolkit (2022).*

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# Recommended Screening Tool: The Mood Disorder Questionnaire (MDQ)



- Brief, self-report questionnaire. Validated for use in perinatal populations

| Bipolar disorder (MDQ) | Keep going…. Circle the letter that indicates: Has there **ever been a period of time in your life** when you were not your usual self and… | |
|---|---|---|
| | **NO** | **YES** |
| …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? | N | Y |
| …you were so irritable that you shouted at people or started fights or arguments? | N | Y |
| …you felt much more self-confident than usual? | N | Y |
| …you got much less sleep than usual and found you didn't really miss it? | N | Y |
| …you were much more talkative or spoke much faster than usual? | N | Y |
| …thoughts raced through your head, or you couldn't slow your mind down? | N | Y |
| …you were so easily distracted by things around you that you had trouble concentrating or staying on track? | N | Y |
| …you had much more energy than usual? | N | Y |
| …you were much more active or did many more things than usual? | N | Y |
| …you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night? | N | Y |
| …you were much more interested in sex than usual? | N | Y |
| …you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky? | N | Y |
| …spending money got you or your family into trouble? | N | Y |
| Please place a check mark in the NO or YES column to answer the following two questions: | | |
| If you checked YES to more than one of the above, have several of these ever happened during the same period of time? | N | Y |
| Have any of your blood relatives (i.e., children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder? | N | Y |
| Scoring: Total the number of Y responses above the grey bar containing the text beginning with "Please place a …" A **score ≥ 7** is a positive screen. Use page 21, "Bipolar disorder" section and pages 27 and 28, Bipolar Disorder Treatment and Management, for treatment options. | | |

*Citation: Hirschfeld, R. M., et al. (2000). Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. The American journal of psychiatry, 157(11), 1873–1875.*

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# How to Interpret the MDQ

- Scoring criteria for a positive screen (typically ≥7 "yes" responses to the 13 items in question 1, plus "yes" to question 2, and "moderate" or "serious" to question 3).
- "A positive screen is a red flag, not a diagnosis."

*Citation: Frey, B. N., et al. (2012). Sensitivity and specificity of the Mood Disorder Questionnaire as a screening tool for bipolar disorder during pregnancy and the postpartum period. The Journal of clinical psychiatry, 73(11), 1456–1461.*

# The First 5 Minutes: Immediate Steps After a Positive Screen



- **Assess for Safety:**
  - Suicidal ideation/behavior.
  - Homicidal ideation.
  - Psychosis (hallucinations, delusions).
  - Severe impulsivity or risk-taking behaviors.
- **Action:** If any are present, initiate emergency psychiatric evaluation.
- **Collect relevant data if able:** past psychiatric history, past medication trials, previous mood history during prior pregnancies
- Suspicion for bipolar disorder generally requires specialty care with psychiatry
  - **Call the access line** for referrals and for further guidance from reproductive psychiatry: **833-978-6667**

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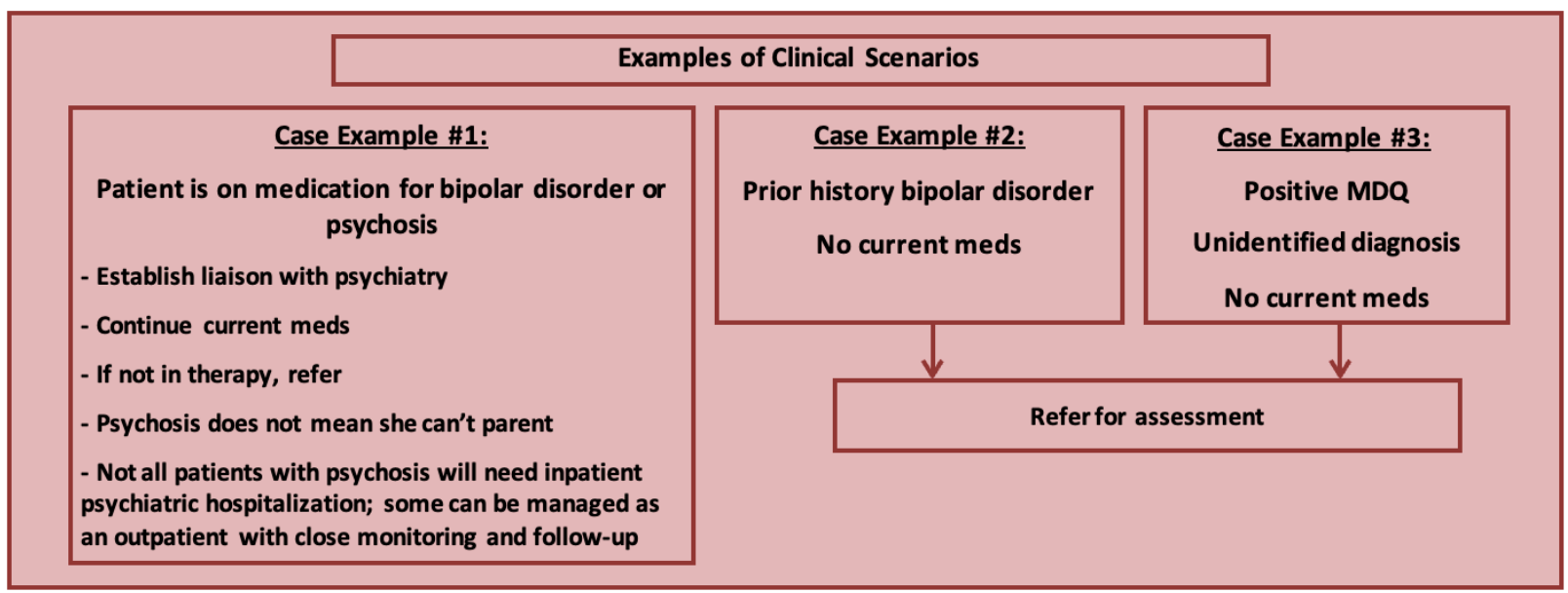
# Perinatal Bipolar Disorder Management



- A collaborative, shared decision-making approach is essential.
- Goals: Maintain mood stability.
- Minimize risks to mother and fetus/infant.
- Prevent relapse, especially in the postpartum period.



# Calling the ACCESS line

**Have the following information ready:**

- Patient's age and gestational week.
- MDQ score and specific "yes" responses.
- Summary of your immediate assessment (safety, key history points).
- The specific question you have for the consultant.

**We will then share:**

- Confirmation of the urgency of the situation.
- Guidance on further assessment.
- Recommendations for initial management, including med selection.
- Advice on communication with the patient.
- Case management for referrals or other resources (such as support groups, diaper banks, etc).

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# Communicating with the Patient

- Use a calm, non-judgmental, and validating approach.
- Explain that the screen suggests a need for a more in-depth conversation about her mood.
- Emphasize the goal is to ensure her and her baby's well-being.
- Provide psychoeducation about the importance of addressing these symptoms.
- Share next management steps, if any.
- Inform her that the ACCESS line case manager will call her back (if the patient requires referrals for psychiatry or therapy)

# Pharmacotherapy: General Principles

- Discuss risks of untreated illness vs. risks of medication exposure.
- Monotherapy is preferred when possible.
- Use the lowest effective dose.
- Consider pre-pregnancy response to medication.

**If patient cannot be assessed by a psychiatric provider in a timely manner:**

**- One option is to prescribe quetiapine (Seroquel) because it can treat unipolar and bipolar depression as well as mania and psychosis until patient can be assessed, and diagnosis clarified**

**- Start with quetiapine (Seroquel) 100mg qHS, increase by 100 mg increments as needed up to 800mg/day**

*Citation: Galbally, M., et al. (2017). The management of bipolar disorder in the perinatal period: A review. Journal of affective disorders, 219, 123-132.*

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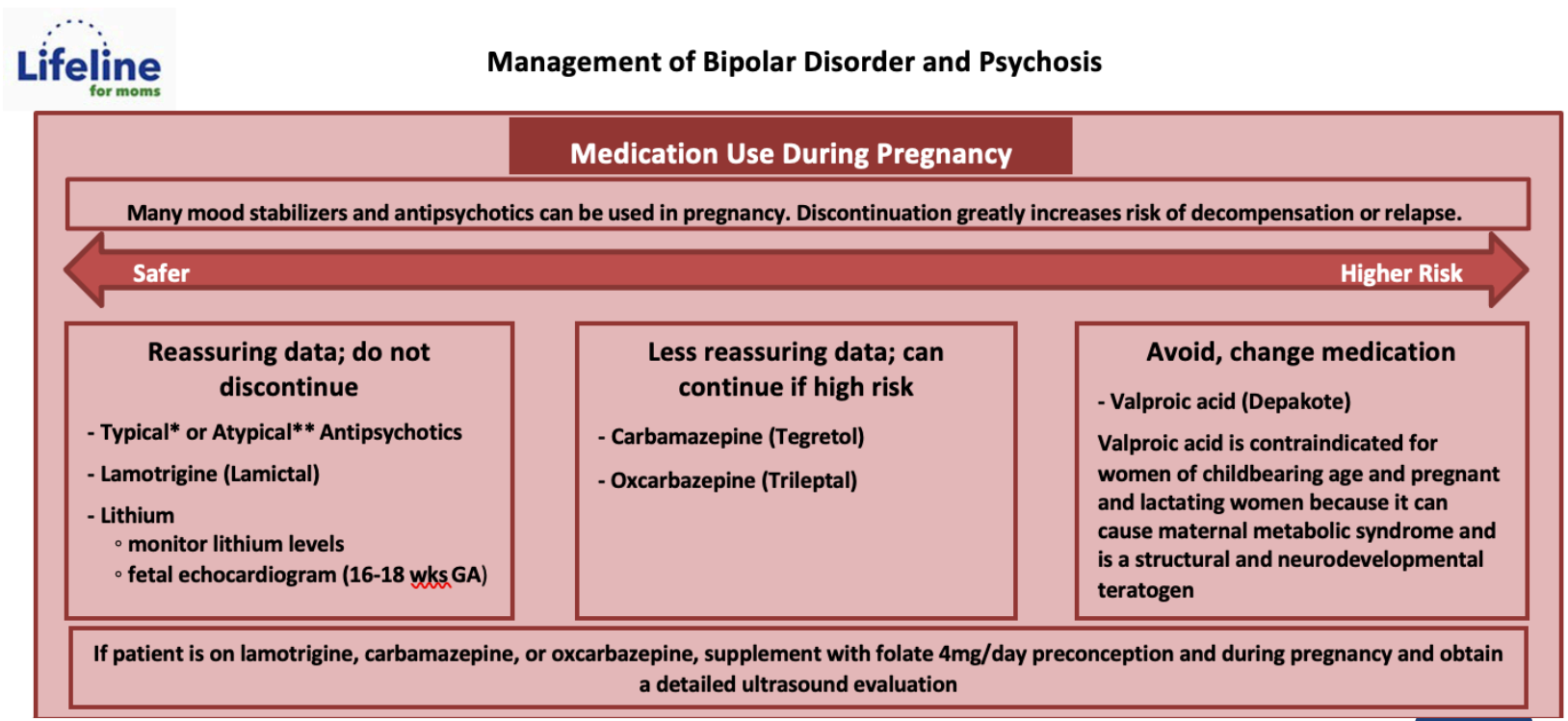
# First-Line Mood Stabilizers in Pregnancy



- **Lamotrigine (Lamictal):** Generally considered a safer option for bipolar depression.
- Dosing needs to be adjusted during pregnancy.




*Citation: ACOG Committee Opinion No. 809: Management of Mental Health Conditions During Pregnancy and Postpartum. (2020). Obstetrics and gynecology, 135(6), e261–e269.*

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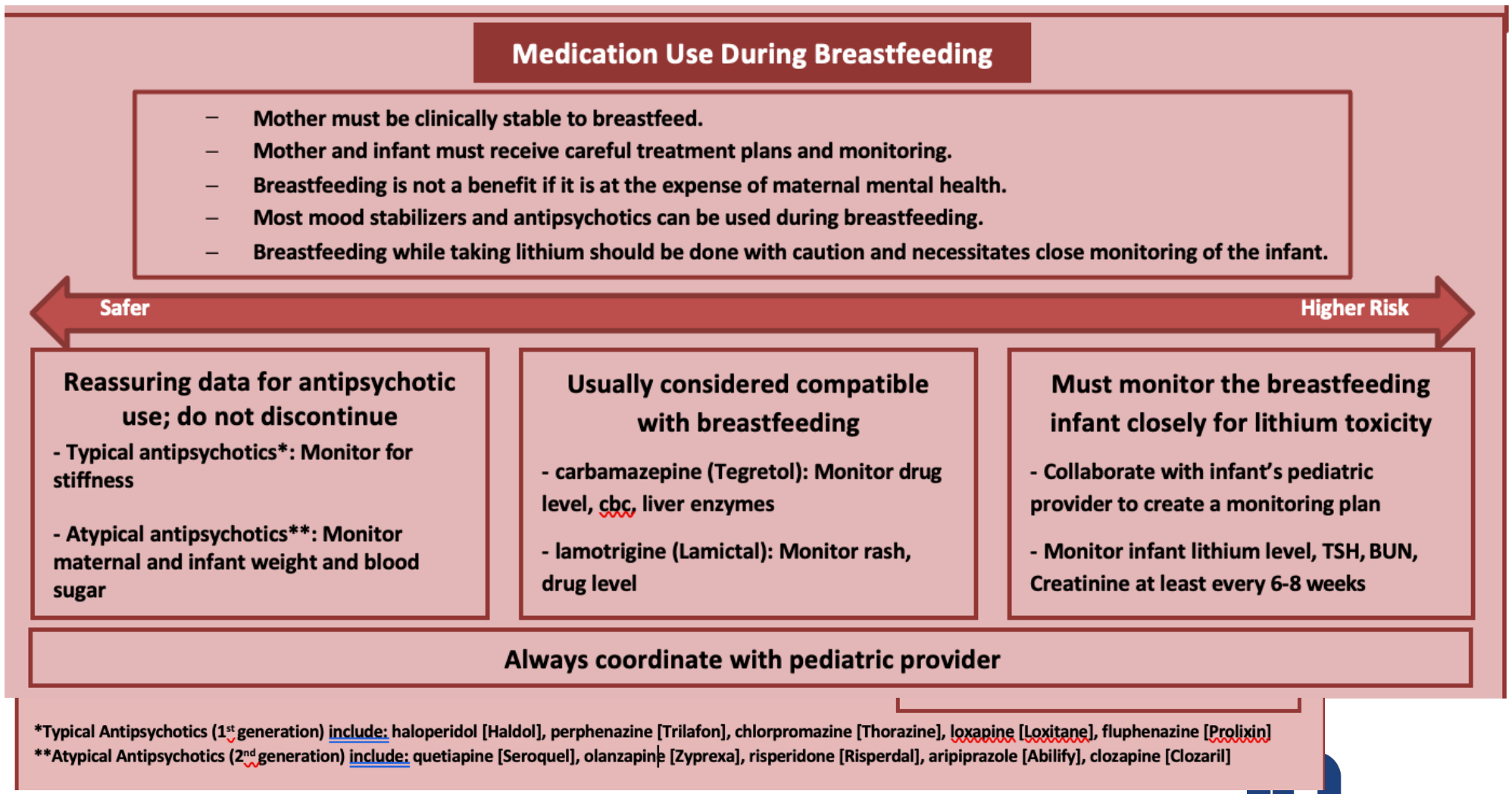
# Considerations for breastfeeding



# Non-Pharmacologic Strategies

- Psychotherapy can be very helpful in building stable routine and coping skills
- Psychoeducation for the patient and her family.
- Emphasis on sleep hygiene.
- Stress management techniques.
- Building a strong support system.

## General Management Strategies

**To decrease and manage risk of decompensation:**

- Prophylactically treat with a mood stabilizer and/or antipsychotic
- Develop post-birth plan (e.g., clear follow-up plan for after delivery)
- Monitor closely (patient may not recognize labor cues)
- Collaborate with newborn medicine/pediatric provider
- Develop a plan for breastfeeding
- Develop a plan to support adequate sleep (e.g., partner feeds baby at night)
- Develop a plan to support maternal-infant bonding (e.g., engage family in postpartum plan)

**Mania or postpartum psychosis:**

Patient needs to be evaluated by a mental health provider. This can be done through psychiatric emergency services or as an outpatient depending on acuity level and safety concerns.

*Typical Antipsychotics (1st generation) include: haloperidol [Haldol], perphenazine [Trilafon], chlorpromazine [Thorazine], loxapine [Loxitane], fluphenazine [Prolixin]
**Atypical Antipsychotics (2nd generation) include: quetiapine [Seroquel], olanzapine [Zyprexa], risperidone [Risperdal], aripiprazole [Abilify], clozapine [Clozaril]

# Key Takeaways

- A positive hypomania screen is a significant finding that requires prompt attention.
- A systematic approach to assessment and management is crucial.
- Collaboration and consultation are key to providing safe and effective care.
- When in doubt, call the ACCESS line

# Thank you!

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**Contact ACCESS:**

**Monday through Friday, 9:00 am – 5:00 pm**

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