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DEBATE

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Practical lessons learned for assessing and treating bipolar disorder via telehealth modalities during the COVID-19 pandemic

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In August of 2019 we published a brief commentary in *Bipolar Disorders* concerning the role of telemental health via videoconferencing (TMH-V) in the treatment of bipolar disorder.[1] We concluded that this technology has great potential to improve access to evidence-based mental health treatment.

With the onset of the COVID-19 pandemic, distance care (including phone and TMH-V) is now becoming the default treatment modality for many mental health clinicians. Given our longstanding experience delivering TMH-V to patients with bipolar disorder in the US Department of Veterans Affairs,[2,3] we wanted to provide some practical guidance for clinicians who may be new to treating patients diagnosed with bipolar disorder virtually.

First, we note that there are several foundational steps to take when delivering TMH-V or treatment by phone regardless of the patient's diagnosis. These steps are intended to maximize patient safety while minimizing ethical and legal risks for clinicians (eg, developing clear procedures for handling behavioral emergencies is paramount). Other authors cover these steps in more detail elsewhere[4] and we recommend that practitioners familiarize themselves with these practices. We also recommend that clinicians periodically revisit the mandates and regulations that may apply to them, as many state and organizational policies have been changing rapidly during the COVID-19 pandemic.

Beyond these general considerations common to virtual care, there are special considerations relevant to the evaluation and treatment of patients with bipolar disorder via TMH-V. In cases where wireless connectivity or equipment issues may require a conversion of a video session into a telephone session, we have also included telephone considerations as well.

Assessing certain aspects of speech, affect, and psychomotor agitation may require more effort when delivering virtual care compared to in-person care. For instance, apparent changes in speech volume or tone may be an artifact of microphone placement or speaker quality. Clarifying a patient's words, slowing down the conversation, adjusting volume or position of the patient to the

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microphone will help diffuse any trouble in hearing the patient. Similarly, if you are unsure if a patient is tearing up, trembling, or experiencing psychomotor agitation, it is important to ask them directly. If you cannot see the patient in a TMH-V session clearly due to poor lighting, camera angle, or the patient carrying the device in their hand, ask them to reposition themselves or set the device down on a flat surface. Asking the patient to stand up and walk a few steps in front of the camera can be used to assess motor performance.[5] In fact, seeing symptoms of restlessness may be enhanced during TMH-V sessions, especially if someone is standing or walking around in their home during a visit.

When TMH-V or telephone connections feature significant lag, it may be difficult to interpret apparent interruptions or changes in voice prosody. The patient may be attempting to speak during lulls in the conversation, and may sound to the clinician like they are cutting in or not listening. Patients may be harder to interrupt due to pressured speech, simply because visual cues that the clinician is trying to talk may be absent or delayed. One should be aware of these possibilities, and talk about them directly with the patient, rather than assuming that such instances indicate manic symptoms.

For patients who may experience paranoia, derealization, or hallucinations, TMH-V modalities may be particularly stressful, especially if the focus of the patient's paranoia is on issues of surveillance. A patient may ask that the TMH-V provider's camera pan the room to demonstrate that no one else is surreptitiously watching the session. In these cases, clinicians must take time to process novel experiences with the patients afterward and discuss healthy strategies for coping after the session. The clinician may have the opportunity to present grounding exercises, inquire about self-management skills the patient routinely uses, and provide psychoeducation on how their treatment model will assist the patient in working with these symptoms.

With the emergence of COVID-19, many people are reporting a loss of coping strategies at present (eg, the gym, more easily accessible social interactions). Social isolation and self-quarantine may be particularly disruptive given the importance of routines and predictability around social rhythms and sleep for many patients with bipolar disorder. Treatments may need to emphasize alternative activities that can be done at home (eg, participating in online groups, engagement with in-home activities, etc.). The simple loss of usual routine may be a trigger for manic/hypomanic or depressive episodes for patients with bipolar disorder. Certain symptoms, such as shopping behaviors, may have migrated online, whereas other symptoms (eg, impulsive relationships) may have decreased. It is important to not assume; instead, assess for changes in functioning given novel outlets for various habits in the time of COVID-19.

Delivering care for patients with bipolar disorder via TMH-V or telephone presents unique opportunities and challenges. In addition, COVID-19 and the associated public health and social responses pose its own challenges for patients with bipolar disorder. TMH-V provides an invaluable opportunity to interact with and support patients even under circumstances of social isolation. It is our hope that the issues discussed herein will be helpful for those clinicians who are adjusting to the use of virtual care for patients with bipolar disorder.

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