Bipolar Disorder and Substance Use Disorder

Introduction

While everyone goes through periods of ups and downs in their moods, bipolar disorder causes severe fluctuations in a person’s mood, activity, and energy levels. Bipolar disorder is a mental illness that involves periods of extremely elevated moods and increased activity interspersed with low periods of depression. The patient with bipolar disorder does not necessarily have regulated bouts of highs and lows, but instead experiences erratic mood changes. Some mood elevations may be short lived and followed by severe depression. Later bouts of mania may be longer lasting and then followed by essentially normal behavior. The range of symptoms and their intensity vary between individuals. Coupled with a substance use disorder, treatment for the individual with a comorbid condition can be difficult. Clinicians diagnosing a comorbid condition have new criteria in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) that help to guide the patient’s treatment plan.

DSM-V Criteria To Diagnose Substance Use And Addiction

This section outlines some of the key changes in the DSM-V, which clinicians need to understand in determining a dual diagnosis of bipolar disorder and a substance use disorder and issue of addiction. The DSM-IV separated the criteria to diagnose substance abuse versus substance dependence. A substance abuser was identified as a person who tended toward recurrent and recreational binging interspersed with periods of not using; whereas, a person with a dependence disorder was identified to have a persistent, compulsive use of a substance.

Recreational binging can lead to unfortunate outcomes, however, its
important for the clinician to distinguish between that level of substance use and one associated with a mental health disorder and a maladaptive pattern of substance use. When evaluating an individual for maladaptive patterns of substance use, the clinician would want to consider the patient’s history of, for example, driving a vehicle under the influence, problems with law enforcement or legal issues, such as assaultive behavior, poor performance at school or work, and conflict in family or other relationships.

Two major changes in the DSM-V include: elimination of separate categories of substance use and substance dependence; and, criteria inclusive of new language in the DSM associated with “addiction and related disorders”. An individual diagnosed under the DSM-IV criteria as having a “substance abuse” problem is instead evaluated according to DSM-V criteria for a “substance use disorder” and considered for treatment of an addictive disorder. The DSM-V establishes no sharp distinction between substance abuse and dependence; instead, the new criteria reflect a decision of DSM-V working groups that suggest abuse and dependence lack a clear demarcation of boundary and are of one dimension.

Critics of the DSM-V argue that the new criteria to diagnose a mental health and substance use disorder lack clear boundaries and appear too vague and prone to an overlap of conditions. This is an ongoing debate for thoughtful clinicians to be aware of when attempting to use the new DSM criteria to diagnose and to develop a treatment plan, hopefully in collaboration with other members of the mental health team. The following sections incorporate the new language and criteria of the DSM-V to diagnose co-existing bipolar disorder and substance use and addiction disorders.
Bipolar Disorder Classifications

Bipolar disorder may be classified as different states, which are categorized according to their symptoms and effects on the patient. A person is diagnosed with bipolar I disorder after having at least one manic episode and one depressive episode in an alternating pattern. The episodes must have lasted at least seven days. Often, the alternating moods significantly affect the person’s behavior and quality of life and may lead to negative consequences. Many patients struggle with symptoms for months at a time.

Bipolar II disorder is characterized by alternating periods of depressive symptoms and hypomania. Bipolar II disorder includes more episodes of severe depression when compared to mania; the hypomanic episodes must last at least four days’ duration, although they are often much longer. Because bipolar II disorder is predominantly associated with depressive episodes, the patient with this category of bipolar disorder is at higher risk for suicide when compared to a person diagnosed with bipolar I disorder.

Bipolar disorder is actually classified as a spectrum of illness, rather than one specific condition. A patient diagnosed with bipolar disorder may be categorized as having type I or type II, or may have another form that is either called cyclothymia, or as bipolar “with mixed features”. Cyclothymia is less severe than either bipolar disorder type I or type II; it is sometimes considered to be an antecedent to bipolar disorder, but for some people, cyclothymic disorder is chronic and long lasting. Cyclothymia is characterized by less severe symptoms of mania or depression, with a greater tendency toward irritability with mania instead of euphoria. A patient with cyclothymic disorder may have symptoms that last two months or more and may have struggled with these alterations for more than two years.
Bipolar disorder used to have another diagnostic category that was known as bipolar disorder *not otherwise specified* (NOS), which acted as something of a catch-all for symptoms that were not classified as bipolar I, bipolar II, or cyclothymic disorder. Furthermore, a patient could also be considered to have mixed episodes, in which the person experiences symptoms of mania and depression at about the same time. With development of the DSM-V, the NOS category has been replaced by *Other Specified Bipolar and Related Disorder*, which considers those patients who have variations of type I or II but do not exactly meet the criteria. The mixed episodes portion of the diagnosis has also been changed to add *specifiers*, which include a specifier for mixed episodes and a specifier for anxiety.

Although the technical aspects of diagnosis may be complex when comparing patient symptoms and symptom duration, bipolar disorder, whichever form it may take, can lead to serious problems, including substance use and addiction. The condition requires careful management through combined medication and counseling to control symptoms and to manage behavior to avoid life-altering complications.

**Causes Of Bipolar Disorder And Demographics**

The exact causes of bipolar disorder are not entirely known, although studies have shown that it is most likely the result of a combination of factors, including neurochemical changes in the brain that affect neurotransmitter levels, environmental influences, and family history and genetic factors.\(^1\,^2\) The alterations in neurotransmitters associated with bipolar disorder most commonly affect changes in dopamine, serotonin, and norepinephrine. It is also thought that some of the genetic factors affiliated with bipolar disorder are similar to or share characteristics of those associated with schizophrenia or some anxiety disorders. People with a family history of other kinds of
mental illnesses, such as anxiety disorders, attention deficit hyperactivity disorder (ADHD), depression, and schizophrenia are also at higher risk of developing bipolar disorder.\textsuperscript{6}

A person may be genetically predisposed to developing bipolar disorder and then may be exposed to environmental influences that further support development of symptoms. For example, a young adult who is genetically predisposed to the condition may not have struggled with emotional or behavior problems while still in his or her teens or during college, but due to environmental factors that have developed, such as the stress of a job, marriage, and raising children, may start to suffer from regular episodes of mania and depression. Traumatic stress, such as that caused by emotional damage or enduring a painful experience, may also be considered as an environmental factor that triggers bipolar symptoms. To better understand the bipolar disorder spectrum, it is first important to recognize those at risk of developing the disorder and the most common factors that increase the possibility of developing bipolar disorder.

**Age**

Bipolar disorder can affect anyone of any age, but it most commonly develops in teens and in young adults. The average age of onset is 25 years, with the most common diagnoses occurring between 15 and 30 years of age.\textsuperscript{6} Bipolar disorder may develop among young adults who have grown through their teen years and are completing their neurological development and moving into times of more responsibility, such as starting careers, getting married, and having children. Younger patients, particularly men, are more likely to engage in dangerous or aggressive activities during bipolar episodes; they have also been shown to be more impulsive and to be at
greater risk of a substance use disorder when compared to older adults with the same illness.\textsuperscript{14}

Because bipolar disorder and substance use occur together so frequently, experts often recommend that any young adult or adolescent diagnosed with bipolar disorder should also be screened for a substance use disorder.\textsuperscript{46}

Those who experience mixed states and rapid cycling are at highest risk of developing substance use problems, but anyone who struggles with the mood swings associated with bipolar disorder is considered at risk.

Substance use often starts in adolescence and young adulthood, during a time when experimentation and peer pressure is high. Adolescents who use drugs or alcohol regularly during the teen years are at higher risk of having problems with substance use and addiction later when they become adults. A concurrent bipolar disorder magnifies the situation, so that the teen or young adult may be struggling to cope with many symptoms at once. Adolescents are also notoriously known for mood swings and the effects of hormone changes in their behavior. A teen may be placid and compliant with his or her parents one day and raging and arguing the next. Adolescence can be a very confusing time, even for a teen who does not have a mental illness.

When an adolescent or young adult is diagnosed with bipolar disorder, the mood changes and other symptoms associated with the illness can be overwhelming. The individual may turn to alcohol or drugs to experience some relief, which can quickly become problematic when the person uses substances regularly to cope with mood changes. Lack of supervision, hands-off parenting, and struggles with environmental influences can also lead to problems with substance use. All adolescents need positive role models and guidance from their parents as they make choices about school,
careers, and relationships, as well as choices about whether to use drugs or alcohol. Adolescents diagnosed with bipolar disorder are at particular risk of making poor choices and often need someone who can set a positive example as well as to help them manage their emotions and stay away from drugs and alcohol to avoid developing substance use problems or addiction.

Because drug use most commonly starts during adolescence, the person with bipolar disorder who starts to use drugs and alcohol may be at higher risk of developing long-term problems. As an adolescent undergoes neurobiological changes as part of development, and continues to gain greater abilities in such activities as decision-making, cognitive learning in school, memory and retention, and social skills, he or she becomes more mature physically and psychologically. These neurodevelopmental changes continue into young adulthood. However, when a teen starts to use drugs or alcohol, he or she may disrupt many of the changes that have been taking place as part of development. This may further implicate a connection between mental illness and a substance use disorder and addiction because of the average age of onset of bipolar disorder. In other words, a teen who starts to use drugs and alcohol while still in high school or college is at greater risk of developing a substance use disorder later in young adulthood, which is also about the same time that bipolar disorder is most commonly diagnosed.

Bipolar disorder may also develop in children and the numbers of children diagnosed with bipolar disorder continues to increase. Approximately 20 percent of adults with bipolar illness are thought to have had symptoms dating back into childhood, but they may or may not have been diagnosed during that time.\(^7\)
There is no differentiation between ages when giving diagnostic criteria for bipolar disorder. The diagnostic criteria for bipolar disorder are the same for a 40-year-old as they would be for a 10-year-old. However, a child typically demonstrates differences in behavior when compared to an adult, which can be seen during the assessment and diagnostic phases of caring for these patients, although, these behavior differences do not necessarily change how the condition is diagnosed. The potential for overlapping conditions also complicates the diagnostic process. For instance, a child may have ADHD and may struggle with impulsivity and hyperactivity, which can be similar to mania. This can make diagnosing children with bipolar disorder much more difficult.

One method of diagnosing bipolar disorder in children and teens is to utilize the Child Bipolar Questionnaire (CBQ), which is a series of questions given to parents and caregivers about a child’s behavior that can indicate the presence of mania or depression. The questionnaire is useful in that it can also rule out other comorbid conditions of childhood that may be associated with, or mistaken for, bipolar disorder, including ADHD, oppositional defiant disorder, conduct disorder, or obsessive-compulsive disorder. The questionnaire can be administered in a relatively short period of time to a parent. It tests not only whether the child is behaving in a certain manner or is struggling with some symptoms, but it also has the caregiver relate the extent of the child’s struggles.

A tool such as the CBQ can be very useful in helping a provider diagnose bipolar disorder in a child. While it may seem that diagnosing bipolar disorder in a child is unrelated to substance use issues, as childhood substance use is much less common when compared to adolescent or young adult substance use, the clinician should consider the brief period of time
between childhood and adolescence and the potential for a substance use disorder to develop. If a healthcare provider can identify and treat bipolar disorder when the patient is a child, it can potentially prevent the development of substance use problems later when the child is older.

Older adults may also develop symptoms of bipolar disorder and may be diagnosed late in life. An older adult who is diagnosed with bipolar disorder after 50 years of age is referred to as having late-onset bipolar disorder. Approximately 10 percent of people diagnosed with bipolar disorder have late-onset bipolar diagnosis. An older adult may have lived for many years with symptoms of bipolar disorder, yet may have never been diagnosed. In these cases, the condition may have been present and the person struggled with bouts of depression followed by uncontrollable episodes of mania, but for various reasons, the affected person was not actually diagnosed until later in life.

Alternatively, some older adults who are diagnosed with bipolar disorder have lived relatively stable lives when they were younger but, due to changes in their lives, have struggled with symptoms of the illness. Changes associated with retirement and loss of a spouse or loved one can create feelings of isolation and lead to variations in schedules and social activities. The older adult may have long periods of time of isolation and loneliness, followed by social activities that are busy and tiring. Older adults who are diagnosed with late-onset bipolar disorder tend to have longer hospital stays when compared to younger adults. Furthermore, older adults may suffer from more symptoms or greater intensity of symptoms because of other factors, such as the sensory changes associated with aging or the use of more than one medication. For example, a bipolar patient may also have prescriptions for a number of different medications to treat various medical
conditions. The interactions of these medications and their potential side effects can worsen the symptoms of bipolar disorder and can trigger mood disturbances.

Another known factor associated with the illness is that people with bipolar disorder who start relationships or marry have been shown to increase chances of marrying or forming relationships with others who also have bipolar disorder. Persons with bipolar disorder tend to be drawn to others who also have the condition. The reasons for why this occurs are unclear, and may be related to genetic or environmental influences. For instance, a person who struggles with feelings and behaviors associated with bipolar disorder may be drawn to another person who feels the same way because of their shared experiences. This may be problematic when two people with similar symptoms start a relationship, as the negative effects of the illness may cause difficulties with communication and may hamper the couple’s ability to relate. If a substance use disorder develops in both people, the outcomes can be even more damaging, as the couple may use drugs or alcohol together but may also have a difficult time overcoming addiction at the same time.

**Gender**

Both men and women are equally affected by bipolar disorder, with no increase in the rate of diagnoses found in one gender over another. However, women are more likely to struggle with mixed states or rapid cycling. Furthermore, substance use that occurs with bipolar disorder is more common in men; and, men diagnosed with bipolar disorder tend to have more severe conditions than women. Men are also more commonly diagnosed at younger ages than women.
Twin studies have shown that a person is at higher risk of developing bipolar disorder if he or she has a twin with the condition. A person who has a fraternal twin, whether it is a brother or a sister twin, has a 20 percent higher chance of developing bipolar disorder if the twin sibling has the illness. Fraternal twins share some genetic characteristics but are simply brothers or sisters born at the same time because of egg development at conception. Alternatively, identical twins, which are always either boy-boy or girl-girl combinations have higher risks of both persons having bipolar disorder. Among identical twins, if one twin has bipolar disorder, the other twin has a 60 to 80 percent chance of also developing the illness.¹ The traits between identical twins are much more intertwined when compared to fraternal twins because of their circumstances at conception.

A man diagnosed with bipolar disorder may exhibit clinical symptoms differently than a woman diagnosed with the same condition, particularly in terms of psychosocial functioning and expressed quality of life. Men may suffer from manic symptoms more frequently than women; alternatively, women may more likely experience depressive symptoms of bipolar disorder when compared to men. Comorbid disorders develop among both men and women, but the risks of developing certain disorders are different when compared to men and women. For example, women may more likely experience comorbid disorders associated with anxiety and eating disorders, as well as symptoms that occur during pregnancy and the postpartum period.⁴⁷

Men may be more likely to develop substance use disorders as comorbid conditions when compared to women. Although women may also develop drug or alcohol use issues with concurrent bipolar disorder, this type of dual diagnosis is more likely to develop among men.⁴⁷ Men have been commonly
shown to use substances such as marijuana, alcohol, opiates, and stimulants while struggling with symptoms of mental illness. Additionally, men are more likely to receive treatment in specialized substance use and addiction centers, whereas women may seek care in primary care settings.\footnote{51}

Mental health treatment centers that specifically manage both bipolar disorder and substance use disorder may treat both men and women together, as studies have shown that there is no difference in treatment outcomes when a person is treated with members of the same gender or with integrated programs with both genders. However, women often seek care in programs that are specifically designed to care for women and that provide support and group therapy with only women who are also struggling with the same conditions.

Many treatment programs recognize the unique aspects of bipolar illness and substance use between men and women and offer specialized care. Although patients may stay in the same facility for treatment, they may be matched with counselors of the same gender or they may meet in small groups for therapy with only those of the same gender. By following these patterns, treatment is aimed not only at helping patients with their co-occurring mental illnesses, but also their specific needs that can affect treatment outcomes, based on gender. For example, some women may struggle more with bipolar symptoms and have difficulties with substance use as a result of hormone release, such as estrogen, during their menstrual cycles. By considering the effects of gender on dual diagnosis, providers may have more success with managing these complex conditions.

**Phases of Bipolar Disorder**
The person diagnosed with bipolar disorder experiences significant changes in mood that affect behavior and personality. For many, these shifts are quite severe, leading to drastic swings between depression and lethargy, followed by mania and periods of increased activity. The phases of bipolar disorder may lead others outside of the condition to consider a person with the condition as being extremely moody or even crazy. In actuality, an individual with bipolar disorder struggles with extreme swings of mood cycles that impact his or her abilities to keep up with responsibilities or to have meaningful relationships. It is for this reason that bipolar disorder used to be called, and is still sometimes referred to as, manic-depressive illness.

Each phase of bipolar illness is referred to as an episode, and these episodes are not always constant. The person diagnosed with bipolar illness may have periods of normal activity and behavior, with episodes that develop at periodic times. The behavior that the person exhibits during an episode is very different from his or her routine behavior. Someone experiencing an episode of mania or depression associated with bipolar disorder may seem vastly different from his or her usual self. Each episode is associated with various symptoms that characterize the phase. Often, when a person with known bipolar disorder is having a mood episode, the symptoms demonstrate which type of phase the person is in, whether it is a depressed, manic, or hypomanic episode.

**Mania**

Mania refers to the period when a patient is in a manic state of overactivity and extreme behavior. While symptoms vary between patients, many exhibit uncontrollable behaviors at times that can lead to problems with relationships, difficulties with completing tasks or maintaining responsibilities, and injuries or financial problems because of poor decision making. A manic episode is classified as symptoms of mood disturbance for
one week or more that include an extremely elevated mood, irritability, and expansiveness. Additionally, the patient must exhibit at least three of the symptoms during that time, as discussed below.\textsuperscript{11}

\textit{Grandiosity}

The person with a bipolar disorder can have very high feelings of self-esteem and personal feelings of self-importance, where he or she perceives themself as elevated above others. This can lead to hard feelings in relationships and can make the manic person difficult to be around.

\textit{Insomnia}

Bouts of insomnia and difficulties with sleeping are common during manic periods. The affected person may have such energy and vigor that he or she is unable to fall asleep or to stay asleep.

\textit{Rapid Speech}

The person may talk excessively, interrupt others, and talk about subjects that are inappropriate for the particular situation. Speech may be rapid and rambling, and speech patterns may not always be clear.

\textit{Racing Thoughts}

The patient may jump from one topic to another during conversation and be unable to stay focused on one subject for very long periods.

\textit{Distractedness}

A person in a manic state may become easily distracted and have difficulty focusing on even simple tasks. This can cause problems when the person...
has responsibilities that he or she needs to complete, such as schoolwork or job duties, and is unable to finish work on time.

**Goal-focused activity**

The individual with a bipolar disorder may experience intense episodes of goal-focused activity, in which he or she centers on an item of interest and invests a significant amount of time and energy into it. During these times, a manic person may actually be productive in completing certain tasks, although often to the detriment of other activities. Some individuals with a bipolar disorder have been gifted enough to complete remarkable creations during a time of mania.

**Pleasure-seeking activity**

The person with bipolar disorder may crave pleasurable activities that may have negative consequences, including using drugs or alcohol or seeking out thrilling or dangerous activities.

In addition to the symptoms outlined above, the patient with bipolar disorder may also demonstrate or experience the following conditions.

- **Euphoria**

  The person may talk about feeling euphoric, excited, extremely happy, or having feelings of ecstasy throughout everyday experiences.

- **Poor decision-making**

  The manic patient may engage in some behaviors that result in negative consequences because he or she was unable to think through to their outcomes. Poor decision-making may include such activities as excessive gambling or shopping, engaging in promiscuous behavior, or driving while intoxicated. This is a dangerous symptom of the manic
phase because it can cause the person to become injured or to hurt others. Some activities, such as spending too much money while shopping, can lead to financial difficulties that the person may later regret.

- **Irritability**

  A common manifestation of mania, irritability, presents as being easily annoyed, stressed, or prone to anger; the person may have outbursts of anger or rage over minor disturbances. While irritability may seem to be an overreaction to the observer, the patient experiencing mania may be struggling with intense feelings of irritation and anger.

The alterations in mood cause changes in behavior and affect that are enough to influence activities of the person with a bipolar disorder, such as his or her abilities to perform at work or maintain relationships. The diagnosis is also made when the person’s erratic behaviors are not the result of other factors, such as substance use.

Some people with bipolar disorder experience periods of psychosis during a manic episode. When this happens, a person may have delusions or hallucinations that are abnormal; for instance, a person experiencing a manic episode may develop delusions of grandeur, in which the person believes that he or she is royalty or an extremely successful and wealthy person. Unfortunately, because of psychotic episodes, the person with bipolar disorder may actually be misdiagnosed as having another type of mental illness, preventing him or her from getting the help needed. When a person is experiencing episodes of psychosis but has not been diagnosed with bipolar disorder, the clinician needs to explore potential causes of the psychosis, considering other factors that may contribute. The clinician may
need to examine the client’s behaviors that are symptomatic of mania, the
time in which the patient has been suffering from symptoms, and a family
history of mental illness before diagnosing a patient with psychosis, as it
may be caused by bipolar mania.

Manic episodes can be harmful to people who act out of control. When a
manic episode lasts for many days, the person may suffer extensively and
may not want to continue feeling the mood elevations associated with the
phase. This is a significant reason why some people with bipolar illness start
to use drugs and alcohol. When they feel out of control during a period of
mania, they may want to come down for a while and have a break from
racing thoughts and out of control emotions and behavior. Often, the
depressant effects of some types of drugs or of alcohol can help a person to
feel calm, even for a short period of time, which can help him or her to find
some relief from mania.

**Hypomania**

Hypomania is a state with symptoms similar to mania, but with less extreme
intensity. While manic symptoms may last for days, hypomania may cause
an alteration in mood that lasts for days or even months. The patient’s
energy and mood levels are elevated above normal, but not necessarily to
the extreme as when mania is experienced.\textsuperscript{10} Because hypomania may last
for a long period of time, the person is often able to maintain routine
activities and continue with responsibilities. However, the individual’s energy
levels or abilities to relate to others may be altered. For example, a person
with bipolar disorder who is in a state of hypomania may still be able to
continue going to work every day, but he or she may accomplish less at
tasks and colleagues may notice that the person is much more distracted.
The person in a state of hypomania may also still engage in high-risk behaviors similar to when mania occurs. However, because the hypomanic symptoms may last much longer than mania, the person is at risk of the negative consequences of his or her behavior for a longer period as well. As another example, a person who has been experiencing hypomania for the past month may spend most nights drinking alcohol in an attempt to feel calm and to slow down a little. Because the person has been drinking for many nights in a row, he or she is at risk of the harmful effects of repeated episodes of intoxication. Hypomania can be a dangerous time for some patients with bipolar disorder because the symptoms are not as extreme as those encountered during mania; the person may believe that hypomanic episodes are normal, and that he or she is fine while, in truth, the person may be struggling for longer periods of time.

Hypomania also leads to elevation of mood and the diagnostic criteria are somewhat similar. The person with hypomania is diagnosed based on at least four days’ duration of symptoms of irritability, euphoria, and expansiveness, plus at least three of the following symptoms:11

- Insomnia
- Grandiosity
- Rapid speech
- Distractedness
- Racing thoughts
- Increased goal-focused behavior
- Pleasure seeking activity

Hypomania shares some of the same symptoms as mania, but without the intensity involved. Because the person experiencing hypomania has symptoms that are less extreme than manic symptoms, he or she may still
be able to function for longer periods. Hypomania also differs from mania in that a person with hypomania does not experience psychotic episodes that may occur during manic periods. Although not all patients with bipolar I disorder in a manic episode experience psychosis, there are many who do have a psychotic episode; alternatively, patients with a bipolar II disorder and hypomania do not experience psychosis.\textsuperscript{56}

A person who is considered to be in a hypomanic state has had symptoms of hypomania for most or nearly all of every day for at least four days. Similar to mania, a patient with bipolar disorder may have many days of normal mood and affect and then have a hypomanic episode, in which the patient’s actions and behavior are vastly different from his or her normal personality. The person’s activity is very unusual for the individual, and he or she may still continue to function to keep up responsibilities, but the person’s behavior may be atypical. For example, a student experiencing hypomania may complete assignments very quickly and may offer to help other students or volunteer to complete group projects; he or she may talk much more than usual, and may seem to have much more energy overall.

Hypomania is also associated with substance use that is seen among people with bipolar disorder. Hypomania may cause a person to feel out of control — particularly if symptoms last much longer when compared to a manic episode as seen with a bipolar I diagnosis. Over time, a person may feel irritable and may tire of the racing thoughts and increased activity and may just want to slow down. Alternatively, hypomania is associated with an increase in pleasure seeking activity and the patient with a bipolar disorder may want to experiment with drugs or alcohol to achieve the effects of euphoria or feeling high that these substances bring. These activities also
put a person with bipolar disorder at higher risk of developing substance use problems when behavior is out of control.

**Depression**

The periods of depression experienced by the person with bipolar disorder can profoundly impact quality of life and the person may struggle to complete everyday tasks or to maintain relationships. Although major depressive disorder (MDD) is a mental health issue similar to the depression experienced during an episode of bipolar disorder and the symptoms may be similar, the person with bipolar disorder does not experience depressive symptoms at a constant pace. Instead, depressive symptoms develop during the time of an episode, which may last for several weeks, and symptoms may be present during most or all of the day during that time. However, when a bipolar patient is not experiencing a depressive or a manic episode, he or she typically has normal behavior and can function in regular responsibilities. The symptoms that develop during a depressive episode are very uncharacteristic as compared to the patient’s normal behaviors. As stated previously, depressive symptoms associated with bipolar disorder are similar to those experienced by a person with major depressive disorder, sometimes referred to as unipolar depression. The diagnostic criteria are also similar in terms of the symptoms experienced and the timeframe in which the affected person suffers from symptoms. Criteria from the DSM-V state that depressive episodes associated with bipolar disorder occur for a significant portion of the day, every day, for at least two weeks and include five or more of the following conditions.

*Changes in appetite*

The person may eat more in an effort to find comfort. Alternatively, the person may eat very little or eat only certain foods because of a lack of
appetite. Controlling food intake is one method of coping with sad or angry feelings and is commonly seen during the depressive phase of bipolar disorder, as well as among people who are diagnosed with major depressive disorder.

*Feelings of sadness*

The patient with bipolar disorder in the depressed state may feel extremely sad, which may or may not be associated with grief or actual loss. The sadness may pervade most activities and the person may feel few other emotions.

*Sleep disturbances*

Sleeping too much or too little both has been associated with depression from bipolar disorder. The affected patient may complain of having difficulties falling asleep and/or staying asleep once sleep arrives, leading to fatigue and exhaustion. Alternatively, some people want to sleep much more than usual and may have difficulties getting out of bed. Depressed patients may take frequent naps or feel very tired during the day, and may have trouble with morning activity of daily living functions, including dressing themselves.

*Slow behavior and psychomotor retardation*

The depressed person may move at a much slower pace than normal. This may cause problems with completing work or participating in activities in a timely manner.

*Poor concentration*

Difficulties with focusing on tasks, poor concentration, and losing focus are all commonly associated with the depressive phase. The person may have
trouble making decisions. Combined with a slower pace of behavior, this can make even minor decisions seem overwhelming and the person may lack any motivation to decide or take action with almost anything.

*Feelings of guilt and hopelessness*

In addition to sadness, the depressed person often experiences feelings of hopelessness, guilt, helplessness, and negative thought patterns. Depression prevents the individual from experiencing much joy or pleasure from anything in life. The person may feel so hopeless as to attempt suicide.

*Fatigue and loss of energy*

The individual with bipolar disorder may be overwhelmed by fatigue and may have a difficult time completing any activities because he or she feels tired and lacks motivation.

*Suicidal ideation*

The affected patient may have a preoccupation with death and may talk of it or make plans for a time after his or her death. The patient may seriously contemplate suicide, develop a plan for suicide, or attempt it.

Of the symptoms listed above, the patient must exhibit at least five, with one of the symptoms being a significantly depressed mood over at least two weeks. As with the diagnosis of mania, the depressive symptoms are unrelated to outside factors, such as a substance use disorder. A patient with bipolar disorder is at risk of developing substance use and addiction problems when depressive symptoms become overwhelming and difficult to handle. He or she may become tired, have difficulties sleeping, lose appetite, and may find that using drugs such as stimulants may help to recharge for a
short period. Alternatively, a person with bipolar disorder who experiences depressive episodes may grow weary of feeling sad and hopeless much of the time, and may start to use drugs or alcohol because these substances temporarily help to feel better by bringing on feelings of euphoria, calm, and happiness. As with other stages of bipolar disorder, depression requires careful monitoring to provide help and to prevent potentially dangerous outcomes associated with substance use. The patient may experience such sadness, grief, or hopelessness that he or she feels few options exist to feel better.

**Mixed Episodes**

At times, a person may experience more than one phase of bipolar disorder at the same time. Referred to as mixed episodes, these incidents occur among people with bipolar disorder who have symptoms of both mania and depression at once. Instead of having both symptoms at the same time, a mixed episode may also indicate a period of depression associated with bipolar disorder that occurs within a very short time of mania or hypomania. For example, a patient may struggle with irritability and guilt and may have thoughts of suicide, but may also have racing thoughts, difficulty concentrating, and he or she may have insomnia.

Mixed episodes are not uncommon; the occurrence of a high rate of mixed states seen in patients with bipolar disorder is part of what brought about a change in terminology when the DSM-5 was developed in 2013. In order to describe mixed episodes in a manner that fully captures its state, the term “mixed episode” was changed in the newest diagnostic criteria. The criteria instead include a mixed features specifier, which can be added to diagnoses of depression or mania in the patient with bipolar disorder.
Formerly, the patient with mixed episodes must have demonstrated symptoms of mania and depression at about the same time. Now, in order to be considered for having a mixed features specifier associated with depression, the person must exhibit at least three symptoms of mania or hypomania that are not overlapping with symptoms of depression. For example, sleep issues are common to both mania and depression; a patient can be depressed and have insomnia, which is also a manic symptom. The symptom of insomnia would be considered an overlapping symptom between the two. Alternatively, symptoms such as grandiosity, racing thoughts, hyperactivity, or impulse control problems do not overlap with depression and would be examples of symptoms that would be considered manic symptoms occurring during a depressive episode that would classify it as mixed features.

If a bipolar patient usually experiences manic or hypomanic symptoms, he or she may have mixed features if experiencing symptoms of depression, such as loss of pleasure in daily activities, feelings of hopelessness, or lack of energy, for at least four days during a manic or hypomanic episode. Conversely, a patient with bipolar disorder who is predominantly depressed may be classified as having mixed features if he or she experiences manic symptoms at the same time for at least two weeks during a depressive episode.

The mixed features specifier has helped some patients who may not have otherwise received a diagnosis of bipolar disorder when the illness was present. Mixed episodes can be confusing, both for the patient suffering with symptoms and the clinician diagnosing the condition. Previous diagnostic criteria left clinicians with somewhat more limited means of determining
whether a patient was truly suffering from mixed episodes of bipolar disorder because the patient needed to be struggling with simultaneous symptoms. Now, a patient may be diagnosed more easily because the definition of what constitutes a mixed state is not quite as narrow.\(^ {39}\) As a result, a patient struggling with both depressive and manic symptoms at nearly the same time may be more likely to receive a diagnosis and to get appropriate help for his or her condition.

Rapid cycling is a state in which a person with bipolar disorder experiences more frequent episodes of mania and depression. The condition occurs in up to 20 percent of those diagnosed with bipolar disorder.\(^ {13}\) Rapid cycling refers to a person with bipolar disorder experiencing four or more episodes of mania and depression within one year. The affected person may have many more than four in a year, and may experience changes in episodes much more frequently. Rapid cycling is an aspect of bipolar disorder, and it is not an illness itself. The person with bipolar disorder who develops rapid cycling does not necessarily continue to have more frequent episodes throughout life. Instead, rapid cycling may fluctuate, with the person experiencing increases in episodes more often during certain parts of life and less often in other times.

Rapid cycling has been shown to be more common among women and in those with bipolar II disorder. Depressive episodes seem to be more common among people who experience rapid cycling. Often, an affected patient may have more frequent bouts of depression followed by short-term periods of mania or even normal moods. Rapid cycling can be difficult to identify, particularly if the patient has not been previously diagnosed with bipolar disorder. Because the person often experiences a depressed state more often than mania with rapid cycling, the condition may be
misdiagnosed as major depressive disorder. However, typical treatment of antidepressants — what would be prescribed for unipolar depression — may make rapid cycling worse and cause more episodes of mania for the patient with a bipolar disorder. Whereas, rapid cycling may be better controlled with mood stabilizing agents to help manage symptoms and to prevent complications.

Mixed episodes and rapid cycling are precursors to substance use and many patients who experience these symptoms are at risk. A patient who suffers from rapid cycling often has more periods of manic or depressive episodes more often than typical episodes of bipolar disorder. As a result, the patient who experiences rapid cycling may suffer from negative symptoms much more often, leading to feelings of confusion, irritation, and emotional difficulties. He or she may turn to alcohol or drugs in an attempt to calm feelings and to help regulate behavior.

As with other types of episodes associated with bipolar disorder, substance use to try to manage emotions or control behavior only worsens the situation. The person may feel the short-term effects of the substance, only to suffer later after the effects wear off. With some types of drugs, the high feelings of euphoria are followed by deep depression when the drug wears off, leaving the person feeling worse than before. This may lead the patient to use the substance again to try to achieve the same effect, causing a cycle of behavior that is destructive.

**Relationship Between Bipolar Disorder and Substance Use**

A person with bipolar disorder is at higher risk of developing problems with drugs, alcohol, or tobacco. The term dual diagnosis is used to describe a person who has been diagnosed with a mental health disorder and with a substance use disorder or addiction. The instances of bipolar disorder and
substance use are high, with many people affected with this mental illness turning to drugs or alcohol. Substance use itself is a mental health disorder, as the chronic use of drugs or alcohol that leads to addiction causes changes in the brain that impact the affected person’s abilities to make decisions. The addicted individual typically reaches the point in the illness that he or she is unable to stop using the substances simply by choice, despite the negative consequences that have happened as a result of substance use.

As mentioned earlier, the DSM-IV defined *drug abuse* and *dependence* as separate conditions, although both situations could develop in a person with bipolar disorder. In the DSM-IV, “drug dependence” was a term used interchangeably with “drug addiction”, in which the person was understood to have a physiological craving for a drug that is often uncontrollable. Drug dependence has also been considered a mental illness because the person with drug dependency experienced actual changes in the brain that affected an ability to function. The affected person would be unable to stop using a substance even if he or she wanted to stop. Alternatively, in DSM-IV, “substance abuse” referred to the repeated use of drugs or alcohol in potentially harmful ways, even when negative consequences resulted. Clinicians may still use these terms collectively as part of a larger diagnostic category now known as *substance use disorders*, classified as either mild, moderate, or severe in intensity.50

The substance use disorder may be further broken down into the specific type of substance causing the problem; for instance, a condition may be classified as an alcohol use disorder (AUD), tobacco use disorder, hallucinogen use disorder, or cannabis use disorder. Whether a person is diagnosed with a substance use disorder depends on the impact the
substance has on the person’s life, such as how it affects behavior, level of impairment, and the risks associated with the substance use.

Although bipolar disorder and substance use disorders are often seen together as comorbid conditions, one condition does not necessarily precede or cause the other. In fact, while at times it may be obvious that one condition led to the development of the other, such as a patient with bipolar disorder eventually developing a substance use disorder because of mood changes associated with the first illness, the clinician does not necessarily need to spend significant time trying to determine which condition came first. Often, in patients with co-occurring bipolar and substance use disorders, it can be extremely difficult to determine if the symptoms are associated with the bipolar disorder, the substance use, or from both conditions. A patient may not be able to relay information about when symptoms started or at what point he or she started using drugs or alcohol.

Substance use and addiction can lead to symptoms of other types of mental illness that can also compound the situation; for example, psychosis has been associated with significant use of marijuana in some people. Determining which condition is the primary disorder typically involves getting the person into a state of sobriety so that he or she is no longer using the substance for a period of time. After this point, the clinician may be better able to determine what symptoms the patient continues to have related to the mental illness. For instance, a person seeking treatment for symptoms of bipolar disorder and alcohol use disorder may have overlapping symptoms associated with both conditions. The individual will need to undergo treatment and become abstinent before symptoms may appear that are associated with the mental illness and not the substance use.
Approximately 60 percent of people diagnosed with bipolar disorder develop some form of substance use disorder as well. The most commonly used substances are tobacco, alcohol, marijuana, and stimulant drugs.\(^{18}\) Patients with bipolar disorder are also more likely to develop other psychological conditions as a result of substance use, including increased anxiety, rapid cycling as a result of bipolar disorder, greater numbers of hospitalizations, and more suicide attempts.

Bipolar disorder and substance use disorders share some common neurobiologic pathways that are responsible for some of the behavioral manifestations that occur with both disorders.\(^ {15}\) In other words, a person with bipolar disorder may have some of the same behaviors as when he or she is intoxicated or using drugs, such as impulsivity, grandiosity, or rapid speech. Substance use can also lead to exaggerated effects of mania, which may cause the person to crave the feelings again and again with repeated use. During a period of mania, a patient with bipolar disorder may experience increased euphoria and excitability, exaggerated by the effects of drugs. The individual may seek to have that same feeling repeated again during manic stages and may continue to use drugs or alcohol to get it. One example of a shared biologic activity is the release and control of dopamine, which is affected not only by substance use disorders but also by other forms of mental illness, including bipolar disorder.\(^ {49}\)

Dopamine is responsible for many functions, including communicating information in the brain, providing feelings of pleasure and enjoyment, and controlling a person’s levels of motivation. When dopamine levels are altered because of a substance use disorder, the affected person may also experience more symptoms of mental illness, which could be another reason why the two conditions are often seen together.
Bipolar disorder and substance use disorders may share some overlapping genes in that a person who has already been diagnosed with bipolar disorder may be more likely to develop a substance use disorder. The National Institute on Drug Abuse has stated that an estimated 40 to 60 percent of a person’s vulnerability to addiction is related to genetic influence. Genetic factors may increase a person’s attraction to certain types of drugs or to alcohol, making it more likely that the affected person will first start using drugs. Genes may also affect how a person responds to stress or even that a person may be more likely to take risks in some areas when compared to other people. When these genes are present in a person with bipolar disorder, he or she may also be more likely to start using drugs or alcohol as a response to stress or to try new experiences and then may develop a substance use disorder and addiction.

Depending on the type of drug used, the person taking it may feel euphoric, giddy, dizzy, and accepted by others; he or she may feel more energy and can stay awake for longer periods when taking a drug such as a stimulant. This is in contrast to the depressed and sad feelings the person may experience during a depressive episode when struggling with getting out of bed and performing daily activities. Alcohol use also temporarily makes a person feel happy and content with decreased inhibition, which can help with social activities or with performing tasks that may otherwise be difficult to complete due to fear. The individual with bipolar illness may drink alcohol to feel less inhibited by his or her condition and to overcome some of the depressing feelings that occur during episodes.

Patients who experience mixed episodes are also at risk of developing problems with substance use. Because mixed episodes cause symptoms of depression and mania at the same time, the affected person may feel even
more confused. He or she may struggle with feelings of hopelessness or guilt, yet also wrestle with racing thoughts and being extremely distracted and unfocused. The person with mixed episodes may turn to drugs or alcohol to combat some of these confusing emotions and behaviors, in an attempt to calm down or to find an element of control. Ultimately, however, the person finds that the effects of drugs and alcohol are only temporary, and is left with many of the same feelings and effects as before.

**Substances as Self-Medication**

Bipolar disorder can cause painful symptoms, with emotions that are difficult to tolerate. The affected person may experience very elevated moods and feel full of joy and happiness, but then later experience crushing depression that saps his or her energy and strength. The person may feel worse when remembering the motivation, happiness, and energy once had when he or she was manic and wonder where it all went. The individual may turn to drugs or alcohol as a form of self-medication to offset some of the painful feelings of bipolar disorder and the psychic pain felt.

The pleasant effects of drugs or alcohol provide a numbing effect to some of the pain the person may be experiencing. This process of self-medicating may be done to forget — temporarily — some of the difficult feelings and emotions associated with bipolar disorder that can otherwise be unavoidable. The practice of self-medication is especially dangerous when the person has not actually been diagnosed with bipolar disorder. He or she may believe that the highs and lows of felt emotions and behavior are normal and that everyone feels the same way. The person with bipolar disorder may struggle with managing his or her own behavior and feelings and, without an actual diagnosis of bipolar disorder, may not understand behavior changes coinciding with the phases of bipolarity and mood swings. Instead of seeking
treatment through medication and therapy, the patient instead may self-medicate to try to control some of his or her difficult or painful feelings.

Because bipolar disorder causes changes in the levels of some neurotransmitters in the brain, the affected patient may turn to drugs or alcohol as a method of regulating and normalizing feelings and emotions. The effects are actually short-term, though, as chronic drug or alcohol use ultimately changes how the body excretes and controls neurotransmitters, leading to instability and potentially erratic behavior. When the effects of the drug or the alcohol wear off, the person is left with the same symptoms as before, as well as further problems due to substance use.

Since co-occurring mood and substance use disorders often worsen clinical symptoms, a person may be more likely to self-medicate to improve feelings of well being. Studies have shown that those with two or more psychiatric conditions, whether or not they include bipolar and substance use disorders, are more likely to state that they suffer from worse symptoms, longer periods of illness, and they utilize hospitals and healthcare services more frequently. Researchers have studied the connection between mood disorders and substance use to determine whether co-morbidities have cause-and-effect relationships. The self-medicating theory has been seen as one type of causative factor that may contribute to substance use when a mood disorder such as bipolar disorder is present.

Further studies have pointed out the self-medication directly impacts a person’s risk of developing a substance use disorder when a mood disorder is present. A study by Lazareck, et al., in the *Journal of Clinical Psychiatry* demonstrated that participants who were diagnosed with mood disorders and who used drugs (either illicit or prescription) or alcohol to self-medicate...
for affective symptoms had an increased risk of developing a substance use disorder by seven-fold.\textsuperscript{36} Stimulant drug usage, such as cocaine and amphetamines, as well as other illicit or prescription drugs, such as opioid medications, place a patient at high risk of addiction because of the qualities of these substances that cause a person to become dependent on them. Although these drugs are used less often when compared to alcohol or marijuana, they can be highly addictive and dangerous for the patient who uses them to self-medicate.

Marijuana (cannabis) often provides a calming effect that some bipolar patients try to find by getting high while experiencing mania. Because manic episodes can lead a person to feel out of control, anxious, or irritable, he or she may enjoy the pleasant and calming feelings obtained from smoking marijuana. Some experts would say that smoking marijuana does not lead to addiction, and its availability for purchase, as well as recent changes in the laws of some states that make it legal to use for recreational purposes, may seem to support this theory. On the other hand, other researchers believe that marijuana can be dangerous and cause a substance use disorder, especially when it is used as a form of self-medication among some patients with mood lability such as in bipolar disorder.

Cannabis is often a pre-cursor drug that is used early on, possibly because it may seem harmless. However, cannabis is a depressant and when used in large amounts, it can be harmful because of excessive effects. Furthermore, it may serve as a gateway drug to open the door to use of other substances, either when it no longer provides as much relief as a form of self-medication, or when the user wants to expand his or her experiences and try other kinds of drugs.
While it is not uncommon for patients with bipolar disorder to use drugs or alcohol as a form of self-medication to manage difficult moods and symptoms, the results can be dangerous. Patients may try to self-medicate, even when they already have prescriptions for medications from a provider for treatment of their bipolar symptoms: they may continue to use drugs and alcohol if they believe that their prescription medications are not effective or to “help” their cause along. Alternatively, some patients do not take prescribed medications or do not seek help from a healthcare provider for treatment of bipolar symptoms and instead self-medicate with drugs and alcohol on their own.

Alcohol, because of its widespread availability and legal use for people over 21 years of age in the U.S., may also be used regularly to combat uncomfortable feelings associated with bipolar disorder as a source of self-medication. Alcohol is a central nervous system depressant and initially produces feelings of slight dizziness, happiness, and a sense of calm. For many people, alcohol decreases feelings of inhibition so that they feel that some shortcomings can be overcome, such as being shy or feeling insecure. The effects of alcohol can be felt by having even one drink, although for someone who ingests larger amounts of alcohol on a regular basis, the level of tolerance is usually much higher. The person then must drink more to achieve the same effects when this tolerance develops.

Although alcohol use may initially increase activity, after a short period, the person then feels tired. Too much alcohol results in a hangover, which often develops after a person has fallen asleep after becoming intoxicated and then wakes up later. A hangover may last for several hours and occurs as the result of the effects of alcohol consumption on the body. The person may have a headache, nausea, sensitivity to light, and dry mouth; some people
also experience heart palpitations and anxiety during this time. Further, the affected person often feels psychologically much worse while experiencing a hangover than when intoxicated. The initial physical affects may make a person feel as if he or she does not want to drink again any time soon, but after a period of time, often the decision is made to drink alcohol again after the feelings have subsided.

For the person who struggles with alcoholism, regular consumption of alcohol occurs because of cravings for it. The individual may develop a compulsion to use alcohol, such that he or she feels a physiological need to have it and may be unable to control how much of an alcoholic beverage is consumed at one given time.

Among the high rates of patients with bipolar disorder, alcohol ranks as one of the most frequently used substances. It can be dangerous because it is relatively easy to access for many people and does not necessarily have to be regulated when a person drinks at home alone. Also, alcohol is often included as part of parties or social gatherings and it may be difficult to abstain from drinking when everyone else in the room is not. The social acceptance of alcohol and its availability make recovery from an alcohol use disorder extremely difficult, even for a person who does not already suffer from comorbid mental illness. When the two conditions are combined, the person can struggle with potentially disastrous effects and may have a very difficult time going through recovery.

Stimulants, while less commonly used when compared to alcohol or marijuana, may still cause problems for some patients who use them and who simultaneously suffer from bipolar illness. Normally, stimulants are taken because they increase energy, and help keep a person awake and able
to maintain focus and attention. A person struggling with bipolar disorder may take stimulants during the depressive phase of the condition, as use of these types of drugs may help the person to feel more awake and may reduce lethargy.

The depressive phase of bipolar disorder can be terribly difficult to cope with for a patient. Instead of feeling the energy and motivation associated with mania, the person may feel extremely hopeless and sad, and may desperately want to achieve a normal state once again. A patient may turn to stimulants as an artificial means of boosting his or her energy and avoiding the despair associated with depression. Drugs such as cocaine, amphetamines, and crystal meth are all stimulants that will produce euphoria and a high that leads to excess energy and wakefulness, but as with other types of drugs or alcohol, these substances can also be very dangerous.

Many people who use stimulants find that they do not achieve the same effects as they once did early in the time of use. While they may be euphoric and happy initially, after a period of time, the pleasant feelings are less and less pronounced. Instead, the person may experience greater feelings of irritability and could feel intense paranoia. When a stimulant use disorder develops, the person also tends to have greater bouts of depression after the drug wears off, leaving him or her feeling much worse than before.61 By this point, the person may have become so addicted to the drug that he or she continues to use it for the physical craving experienced, rather than the effects of the drug. Unfortunately, in an attempt to combat some very negative feelings of depression, stimulant use causes further problems that require the affected person to work harder to overcome.
Because of the frequent connection between a substance use disorder and bipolar disorder, and the fact that it often develops when patients try to self-medicate for their problems, clinicians may have a very difficult time managing both conditions and to help patients to stay on track with treatment. It may be difficult to diagnose bipolar disorder in a patient with a co-occurring substance use disorder if he or she has not been seen for mood disorder symptoms, as substance use can cause many similar symptoms and can exacerbate symptoms of bipolar disorder. The difficulties continue when the patient seeks to take matters into his or her own hands by self-medicating. Although the patient may have tried to feel better by self-medicating, instead, the person complicates his or her own treatment by developing another condition that must also be managed as part of comprehensive care.

**Substances as a Mood Trigger**

As previously stated, a person with bipolar disorder does not necessarily suffer from episodes of mania or depression at a constant pace; instead, he or she may more likely have long periods of normal behavior and emotions that are punctuated by manic or depressive episodes. These mood changes and associated symptoms may occur after some form of a trigger — an event or item that sets off an episode to where the person develops symptoms of his or her illness.

Triggers can take many forms and may be related to environmental factors, physical illness, or relational issues. Some examples include lack of sleep, changes in the family, such as with a birth or death of a family member, exciting events, such as a vacation or an anniversary, conflict with others, and increased amounts of daily stress. Drug and alcohol use can also be
triggers that cause changes in mood and that lead to manic or depressive episodes.

Some patients use substances as forms of self-medication in order to feel better about their mental illness or to help themselves regulate some behavior and emotions. However, substance use may also be a trigger for further episodes of mania or depression, which can only worsen the situation. For example, a patient may drink alcohol to the point of intoxication when experiencing symptoms of mania because he or she wants to feel calm and has been suffering from insomnia. The alcohol use or its effects when a hangover or symptoms of withdrawal develop may act as triggers for further episodes of mania, so instead of solving the symptoms of bipolar disorder, the affected person has only further perpetuated it.

Patients who take medications for treatment of bipolar disorder may also experience more episodes of their illness due to an opposite effect. Medication-triggered mania may occur in some who do not necessarily use drugs or alcohol. As an example, medication-induced mania occurs when a person takes certain medications for the treatment of bipolar disorder symptoms and the effects of the medicines trigger a manic episode.

With some drugs, discontinuing use typically causes the patient to return to normal for a period of time, but symptoms can then return after using some other types of drugs or by returning to substance use again. Some prescription medications may also act as mood triggers and require careful monitoring in order to prevent a relapse into a mood episode. For example, antidepressants might be considered as a form of treatment for the depressive symptoms experienced by a person who suffers from bipolar disorder. However, antidepressants can also trigger an episode of mania.
when they not only bring a person out of depression, but also cause the person to experience a mood swing in the opposite direction. For this reason, antidepressants are often not prescribed for patients with bipolar disorder and clinicians typically choose other drugs to manage symptoms. When a patient does use antidepressants for treatment, he or she must be monitored carefully to ensure that symptoms of mania do not occur as a result of the drug use.

*Switching* is the term used when a patient transitions between high and low ends of the spectrum of bipolar disorder symptoms. A patient with a bipolar disorder may switch between depression and hypomania or mania very rapidly, which may more likely occur if the patient has not been diagnosed with bipolar disorder or if the patient is having a drug reaction. The reaction of a drug that causes a switch in symptoms may perpetuate a diagnosis of bipolar disorder. Switching may occur with the use of some types of antidepressants, as well as with the use of drugs and alcohol if the patient has a concurrent substance use disorder.

Since marijuana is one of the most commonly used drugs among persons diagnosed with bipolar disorder who have concurrent substance use disorders, the drug has often been shown to act as a trigger for mood changes. The substance found in cannabis that causes its psychedelic effects is tetrahydrocannabinol, referred to as THC; this substance may increase the risk of psychosis among people with mental health disorders when large amounts of cannabis are used. A report in the journal *Psychiatry* showed that a person with bipolar disorder who uses cannabis is at risk of developing psychosis associated with mania. Other effects noted from the report include increased incidences of hearing voices, feelings of depersonalization, paranoia, panic, and feelings of persecution.\(^{35}\) The use of cannabis can act
as a trigger to set off severe symptoms of mania in the patient with bipolar disorder.

Alcohol also serves as a mood trigger for some symptoms associated with mania. An alcohol use disorder and addiction have been shown to increase a bipolar patient’s difficulties with impulsivity and to increase risk-taking behaviors that are often seen as part of manic behavior. Patients with bipolar disorder who use cocaine may also have tremendous difficulty with triggering symptoms because of this type of substance use. Cocaine use among patients increases symptoms of post-traumatic stress and antisocial personality symptoms, as well as increases rates of mixed episodes of bipolar disorder. \(^{31}\)

Other medications and substances that have been known to trigger manic behavior and moods include stimulants, such as cocaine, amphetamines, and Ecstasy; and, corticosteroids, thyroid replacement medications, cold medications that contain pseudoephedrine, and caffeine. As mentioned, antidepressants are some of the most well known drugs whose associated effects can cause mania. Mania associated with antidepressant use has been found in up to 40 percent of patients with bipolar disorder. \(^{3}\) The practice of monotherapy, or only using one type of antidepressant in the treatment of bipolar disorder, has been demonstrated to cause episodes of mania more often when compared to using various types of treatments. The antidepressants most often associated with triggering mania include tricyclic antidepressants and serotonin norepinephrine reuptake inhibitors (SNRIs). \(^{4}\)

Alternatively, medication-induced depression can also occur in people with bipolar disorder. The most common substances that have been shown to lead to triggered episodes of depression include corticosteroids, digoxin,
interferon-alpha, and some types of anticonvulsants. Long-term use and higher doses of steroids are more likely to cause depression, and anticonvulsant use has been shown to increase the risk of suicidality among some patients.³

A comprehensive physical and mental exam is important for identifying whether a patient is suffering from a substance-triggered mood disorder. The physical exam can identify whether the patient is suffering from physical complaints from medical conditions that are unrelated to mental illness and bipolar disorder or if they are side effects of medications. For example, a patient may struggle with fatigue as a side effect of a medication, but this does not necessarily result in a medication-triggered episode of depression. Additionally, both the physical and mental exams will help the clinician to identify the onset of symptoms of either mania or depression in relation to starting or stopping certain substances. The provider can then determine if the mood swings and triggered behaviors ended after discontinuing the substance.

In most cases, discontinuing a medication that triggers bipolar disorder episodes is enough to stop the changes from occurring. There are times, though, when a patient needs to be on a medication and cannot discontinue it, even though manic or depressive symptoms have developed from its use. In these cases, the provider may need to change the type of medication the patient takes that may still provide the therapeutic effects without triggering the episodes. The provider may also alter the drug dosages and times of administration to lessen the effects. Finally, there are some situations in which the patient may need to be monitored closely and treated for episodes of mania or depression separately because the triggering substance cannot be changed.³
Both the use of prescription and illicit drugs may act as triggers for mood changes. Whether a patient is prescribed medications for the treatment of bipolar disorder symptoms or uses drugs or alcohol and those substances trigger mood changes, drug use can greatly impact the patient with a bipolar disorder. The challenges of finding treatment methods that do not trigger mood changes can be difficult for some prescribing providers who care for these patients. Furthermore, it is challenging to help a patient with bipolar disorder undergo treatment when he or she is using substances that act as mood triggers. All potential factors must be accounted for when considering the best course of treatment for the patient.

**Impact Of Bipolar Disorder On Substance Use And Addiction Treatment**

Bipolar disorder symptoms complicate the treatment of a substance use disorder and addiction diagnosis. Bipolar disorder is one of the most difficult mental health issues to consistently treat, even when substance use is not present. When a patient has a co-occurring substance use disorder, the requirements for managing both conditions may seem overwhelming. Yet, failing to treat both bipolar disorder and only treating substance use and addiction increases the affected person’s chances of relapsing back into using substances again in the future. Without recognizing the impact of bipolar disorder on substance use treatment, the person may be left with tools for only treating half of his or her symptoms. Dual diagnosis requires that both conditions be recognized and dealt with in order to have a successful outcome of treatment and rehabilitation.

**Manic Phase**
The manic phase is characterized by erratic behavior that causes a person to be revved up in energy and activity. This complicates substance use treatment for various reasons. First, when a person is undergoing symptoms of withdrawal after abstaining from alcohol or drugs, he or she may be triggered to have symptoms of a mood episode. The physical discomforts of withdrawal are often very uncomfortable and some patients need to be monitored closely during the detoxification process. This causes further difficulties if the patient suffers from manic symptoms at the same time. Additionally, the behaviors and emotions the patient with bipolar disorder experiences during a manic episode can make treatment extremely challenging because the patient may have difficulty adhering to the treatment regimens. Drug addiction is associated with increased rates of non-compliance with medication regimens. A manic patient who is undergoing substance use treatment may be less likely to adhere to treatments and may have difficulty following directions for taking medications on time when they are prescribed. If the patient receives medication as a prescription, he or she may not take medication on time or even at all if struggling with symptoms of mania due to bipolar disorder. For example, a patient who has been prescribed naltrexone for treatment of alcohol addiction may receive a prescription to take the drug as an oral tablet of 50 mg every day. When it comes time to take the next dose and the patient is experiencing a manic episode, he or she may be having feelings of grandiosity or expansiveness and may not feel the need to take medication and subsequently refuses to take it.

Even among those patients with bipolar disorder who are very motivated to change and undergo treatment, the demands of treatment can be difficult to commit to and complete. Lack of adherence to medications during manic phases in a patient with bipolar disorder is not uncommon. A report in
Current Psychiatry demonstrated that among patients taking mood stabilizing medications for bipolar disorder, up to 60 percent had sub-therapeutic plasma levels of medications in their bodies, demonstrating non-compliance with taking the drugs on a regular basis. Even among those who choose to undergo treatment and who may sincerely want to go through an appropriate program, the rigors of treatment may be overwhelming and quite challenging to maintain.

The patient may decide to stop taking therapeutic medications, either for bipolar treatment or substance use disorders, during the manic phase because he or she may feel that the drugs are not changing symptoms. Other reasons for non-adherence include an inability to tolerate the side effects of the drugs, forgetting to take the medications because of manic symptoms, and the cognitive changes that develop as a result of taking the medications. Some patients do not appreciate how medications make them feel as part of the treatment of bipolar symptoms; when they experience becoming calm and stable moods because of taking the medication, they may believe they are not themselves any longer and that their personality has changed. Furthermore, some patients may develop anxiety about drug effects or over-analyze drug use to the point that they no longer want to take the medications. Studies have shown that some non-adherence to medication regimens may be more likely to develop among some people simply because of the fear of side effects, rather than their actual experience with side effects.

Patients who have co-occurring substance use disorders in addition to bipolar disorder are at higher risk of more severe episodes of mania and more frequent periods of rapid cycling, as well as a host of other complications, when compared to patients with bipolar disorder who do not
have comorbid substance use disorders. Additionally, patients with a history of substance use, whether as a current disorder or a past history of substance use, are at much higher risk of treatment non-compliance and poor treatment responses.\textsuperscript{33}

A patient with a bipolar disorder who is in the manic phase of illness may also have a difficult time attending appointments and engaging in the activities required to achieve therapeutic treatment. If a therapist agrees to meet with a patient in a manic episode to talk about cognitive-behavior interventions, the patient may have difficulties with focusing on the topic, listening to the therapist while education is being provided, and taking direction to complete the requirements of therapy. The patient may even have difficulties with showing up at their scheduled appointments. These responses stem from some of the major symptoms of mania that cause feelings of grandiosity, in which the patient may believe that he or she is doing so well that attendance at therapy is not needed. Additionally, the patient’s inability to cooperate with treatment may arise from difficulties with focus and concentration, in which the patient may not remember to attend meetings or may forget what was said during the meetings; or, could stem from expansiveness of mood, whereby the patient encounters feelings of boredom with therapy or that it is unnecessary.

When considering the effects of treatment on a patient experiencing mania, the provider may need to help the patient by providing different options that could more likely promote adherence to the treatment plan. For instance, the patient may benefit from inpatient treatment for a substance use disorder if he or she is experiencing mania, as inpatient treatment may be much more regulated and the patient can be monitored closely until some of the manic symptoms abate. A system of close monitoring of the patient’s
behavior and responses to treatment if he or she is manic may more likely provide success in implementing therapeutic treatment during this time.

**Depression Phase**

When it comes to treatment, adherence is a word used to describe a patient’s willingness to cooperate with directions from the provider. A patient’s adherence to treatment indicates that he or she is cooperative and willing to follow the recommendations as given by the provider working with the patient. This may include taking medications as prescribed, attending therapy sessions, or completing “homework” assigned as part of a behavior plan, such as dialectical behavior therapy. The demands of treatment can be challenging to meet and to complete for any patient with a chronic illness, but the requirements of treatment can be especially difficult to comprehend for a patient who is suffering from the depressive phase of bipolar disorder.

Similar to triggers of manic episodes, a patient may also be triggered by substance use to develop depressive symptoms. Periods of substance use or withdrawal may cause a patient to simultaneously experience depression while trying to undergo treatment for a substance use disorder. This can make treatment very challenging when considering that the patient has acute symptoms of depression and may struggle with completing tasks and adhering to the program.

Many different risks are associated with poor response or adherence to treatment among patients with bipolar disorder. Some of these factors include a poor relationship between the patient and the provider, poor understanding of the extent of the illness on the part of the patient, an inability to understand the negative or harmful effects of the illness, fear of side effects from medications, cultural beliefs regarding care and treatment,
and a history of non-compliance with treatments. Some researchers further state that the most important predictor of whether a patient will adhere to treatment for bipolar disorder is whether the patient has a co-occurring substance use disorder. Obviously, the potential for non-adherence to treatment is high, particularly when there are so many factors involved in the process.

The elements involved in determining how a patient will respond to treatment are very complex and they vary between individual circumstances. Some patients with bipolar disorder and substance use may experience many more episodes of depressive illness when compared to mania, which would require some altering of treatment regimens to focus on adapting to depressive symptoms rather than manic symptoms. Other patients may be depressed but have less severity of symptoms; however, they may struggle significantly with a substance use disorder and addiction, requiring focus in that area.

A patient who is going through a depressive stage of bipolar disorder may suffer from extensive symptoms of sadness, hopelessness, and guilt; he or she may have difficulties performing activities of daily living or even getting out of bed. When these types of symptoms are in place and when the patient has difficulty with self-care measures, the extra challenges of following through on treatment may be overwhelming. A patient who cannot get dressed most days of the week because of lethargy from depression is less likely to follow through to get ready and drive to an outpatient therapy appointment.

A depressed patient may also be less likely to adhere to medication regimens when prescribed; often, this is because of a fear of side effects of
the drugs. Some patients do not appreciate the effects of the drugs, whether because of the time it takes for the medications to take effect or the changes that the drugs make to their personalities; often, patients may use drugs or alcohol to enhance the effects of medications, further perpetuating the risks of a substance use disorder.

The patient with a bipolar disorder who is struggling with depression and does not comply with substance use and addiction treatment is at great risk of not only the harmful effects of substance use, but of other factors that are significant as bipolar depressive symptoms. For example, failure to comply and to avoid taking medications or attending treatment may not resolve many depressive symptoms, and the patient may continue to struggle in his or her illness. The patient may drink alcohol or use drugs to combat some uncomfortable feelings, which can further perpetuate substance use and physical addiction, and create a negative cycle of substance use where alcohol or drug use is followed by a phase of recovery after intoxication or feeling high, followed by further depression and by more substance use to feel better. The patient is also at risk of other harmful outcomes related to depression, including self-injurious behavior and suicide.

In cases where a patient is struggling to adhere to treatment regimens because of his or her bipolar disorder, a multi-system approach is often more successful than one single treatment. This involves not only treating both the bipolar disorder and the substance use disorder, but also using more than one modality in the treatment of either condition. For example, the patient may be more likely to respond to treatment that consists of both cognitive-behavioral therapy (CBT) and medication, as each may support the other. The patient may have trouble taking medication on time, but through
CBT he or she may have a better chance of remembering to take medication or to work through issues of non-compliance.

It is important to consider that relapses are common and if a patient relapses into substance use again because of depressive symptoms, the situation should not be treated as a failure, but should instead be considered as a chance to work through more of the patient’s issues, such as whether he or she is having trouble keeping up with the program or is struggling with a bipolar disorder enough to disrupt the ability to maintain sobriety from drugs and alcohol. By further examining these issues, the clinician can better help the patient by coming up with a modified treatment approach that may more likely help in the achievement of success.

**Developing A Treatment Plan**

Historically, a patient with bipolar disorder and substance use disorder were treated separately at different times and in different facilities. Those who needed treatment for bipolar disorder were most likely treated at psychiatric facilities and those with a substance use disorder received treatment with alcohol or drug rehabilitation programs. This may have helped patients to get a handle on their illnesses individually, but it did not necessarily consider the effects of the mental illness and the substance use disorder together. Experts now know that treatment of bipolar disorder and a substance use disorder requires that both conditions be considered and managed in order to provide comprehensive care and to improve the likelihood of control of either situation.

The extent of symptoms related to a bipolar disorder may range from being mild with few episodes of mania or depression, to severe symptoms and increased frequency of manic and depressive episodes with rapid cycling. A
substance use disorder and addiction can complicate treatment when the bipolar disorder is severe. Without proper treatment of a bipolar disorder, a patient is at risk of the consequences of his or her behavior that occurred during manic episodes, as well as a risk of suicide related to depressive episodes. Untreated substance use causes further problems, putting the patient at risk of injuries or death from uncontrolled behavior while intoxicated, as well as chronic medical problems from the toll the drugs or alcohol take on the body.

Treatment of bipolar disorder includes managing the severity of manic and depressive episodes so that symptoms are not debilitating and are not significantly harmful to the patient. Treatment is also aimed at reducing the frequency of episodes; the patient may not be completely free from some symptoms of bipolar disorder, but they can be managed to the point that he or she is not experiencing rapid cycling or frequent episodes. Through treatment, patients can learn to manage their illness not only to control symptoms that occur during manic or depressive episodes, but also to control substance use to avoid developing addiction if it has not already occurred. Addiction that has developed in a patient with bipolar disorder must be treated as well and is often included as part of a comprehensive treatment plan for both conditions.

Treatment of co-occurring bipolar disorder and a substance use disorder and addiction can be difficult, as many of the symptoms associated with each condition overlap. It may be difficult to determine which condition is causing what symptoms. Furthermore, if a patient with bipolar disorder is not properly diagnosed and seeks treatment for substance use, it may appear that he or she is not responding to the substance use treatment if the
symptoms of bipolar disorder that are not being managed continue to manifest.\textsuperscript{14}

Adolescents and young adults who struggle with both a bipolar disorder and substance use disorder need clear guidance and support during treatment and recovery. Because adolescence is often a time of turmoil — even without a mental illness diagnosis — the teen or young adult affected by bipolar disorder and substance use and addiction may be struggling significantly with mood changes and difficulties with thoughts and behaviors as well as cravings for drugs or alcohol that leave the youth searching for more. Treatment of adolescents has been most successful after early intervention.\textsuperscript{46} When parents recognize a problem in their child at an early point of behavior changes and poor choices, early intervention to get the teen or young adult into treatment can be effective. Teens who respond to dual diagnosis treatment programs often do so with therapeutic interventions of psychoeducation, education about substances and their negative and harmful effects, use of medications to help control moods, and close monitoring.

The type of treatment and its delivery depend on the patient’s condition and other factors that are specific to his or her unique situation, such as the patient’s age, the presence of other physical or mental illnesses, and the amount of family support available. Some patients with co-occurring bipolar and substance use disorders are able to undergo treatment on an outpatient basis by living at home and attending support groups and counseling. They may adhere to their medication regimens and meet the requirements for attending therapy as part of the treatment program. Alternatively, there are others who struggle with keeping up with a treatment program and who require more intensive therapy and close monitoring. These patients may
not be able to regularly attend meetings and counseling sessions on an outpatient basis until they are better equipped with tools learned in inpatient rehabilitation.

Outpatient therapy may consist of several approaches, but because bipolar disorder is such a complex illness and is very difficult to treat, some approaches have been shown to be more successful than others. Utilizing therapeutic methods such as cognitive-behavioral therapy or dialectical behavior therapy may be more successful as these approaches involve the patient and the provider working together toward positive outcomes for the patient, which may be more likely to result in success.

**Cognitive Behavioral Therapy**

Cognitive-behavioral therapy (CBT) is a therapeutic process that has been shown to be helpful for patients with bipolar disorder. The method is often used in treating symptoms of depression, anxiety, and some other types of mood disorders, but it can be successful in managing bipolar symptoms as well. CBT is a method that teaches the patient to recognize how thoughts and emotions affect a person’s behavior. Often, a person who struggles with a mood disorder can have self-destructive thoughts that lead him or her to behave in ways that are inappropriate because the thoughts may lead to bad feelings. The cognitive portion of the method involves thought recognition, while the behavioral portion of the method works to change behavior based on changing thought processes.

As an example, a patient with bipolar disorder may act on feelings and thoughts, whether they are true or not. The patient may enter a depressive episode of bipolar disorder and feel guilty and hopeless, and he or she may feel even worse after a negative encounter with a friend with whom there
was disagreement. Because of negative feelings that ensue from such an encounter, the patient may decide to smoke marijuana to help feel better. While working with a therapist and talking about his or her symptoms and responses to those symptoms, the patient realizes that smoking marijuana as a method of feeling better is a response to thoughts of hopelessness. The therapist can help the patient to recognize how negative thoughts contribute to his or her behavior.

Patients are guided during therapy to challenge their thoughts and to determine that, although negative feelings of low self-worth, helplessness or hopelessness may arise, individuals are not what they think and not defined by thoughts. A CBT therapist guides patients to understand that one’s thoughts may or may not be rational or true, and sometimes, it is just a thought without meaning. Patients may need to spend time recognizing the many thoughts that come to mind on a given day and to acknowledge those thoughts, in particular those that are negative or disturbing, so that intervention may be sought before engaging in harmful activities or behaviors repeatedly because of disturbing thoughts. Therapists often work with patients to help them recognize that thoughts are simply thoughts and do not have to direct a person’s behavior. Additionally, therapists may also work with patients to come up with alternative activities that are not as harmful when they develop symptoms of depression.

Often, the counselor or provider who is working with a patient with a bipolar disorder through CBT will develop a set of goals that the patient can work toward as part of treatment. Goals often include developing coping skills and alternative activities so that the patient does not engage in harmful behaviors during periods of mania or depression. The patient may also use the process of CBT to recognize when he or she feels a manic episode
coming on and work to change behaviors to stay safe. Developing mindfulness of one’s mental illness, environmental stressors and patterns of behavior is a strength that can be enhanced during therapy so that individuals with co-occurring bipolar disorder and substance use disorder and addiction can better recognize warning signs and redirect thoughts and behaviors, and to avoid a relapse.

For the patient who is also struggling with substance use and addiction and bipolar disorder, CBT can be beneficial to determine how substance use plays into the patient’s responses to his or her thoughts and feelings. The patient may turn to substances because of self-destructive thoughts and the therapist in this situation can use CBT to help the patient to see how he or she can change thoughts and to avoid turning to drugs or alcohol during difficult circumstances.

A process of using CBT for the management of bipolar disorder and substance use and addiction may involve the patient meeting with a therapist on a regular basis. Often, CBT is used in an outpatient setting, although it can be incorporated into inpatient treatment settings if the patient is hospitalized in a rehabilitation center. The patient and the therapist meet regularly to review the patient’s work toward thought recognition; and, the patient may also have homework between times when he or she must learn to recognize how thoughts can affect behavior and to keep track (possibly through a personal journal or manualized approach to maintain a diary) of those times. This is part of the patient learning to perform these steps on his or her own during recovery from many of the symptoms of a dual diagnosis.
Cognitive-behavioral therapy is different than traditional counseling in that the counselor and the patient work together to develop goals for the outcome of the therapy. CBT tends to be more goal-directed, and involves specific problem solving to help the patient manage and recover from mental illness, rather than using other forms of counseling, such as talk therapy. Studies have shown that CBT can actually change brain activity and improve some symptoms of mental illness; in some situations, CBT has been demonstrated as being as effective as antidepressants for some people who have struggled with major depressive disorder.24

Clearly, CBT is helpful for many patients who struggle with mood disorders and it can be used for those who also struggle with substance use disorders. Because of the complexities of these patients, other forms of therapy may or may not be beneficial in helping patients to actually recognize how they can contribute to personal successes or defeats. CBT can be used alongside other forms of treatment, such as with medications to control symptoms, so that patients can learn how to achieve better control of their illness and find improved methods of coping with the challenges associated with living as individuals having a bipolar disorder.

**Dialectical Behavior Therapy**

Dialectical behavior therapy (DBT) is a method of therapeutic intervention that may be utilized for management of symptoms of a bipolar disorder and co-occurring substance use disorder. DBT may be implemented when other forms of treatment have been unsuccessful, particularly when patients are attempting to manage multiple symptoms and have developed complicated problems as a result of their illnesses. Dialectical behavior therapy was first developed by Marsha Linehan as a method of expanded cognitive-behavioral therapy to work with mentally ill patients to prevent suicide and self-
injurious behavior. It was later expanded to be included as part of treatment for individuals diagnosed with a borderline personality disorder.\textsuperscript{28}

The concept of DBT involves recognizing thoughts and emotions that may be negative or uncomfortable and then accepting them as they are, rather than immediately attempting to change them. When a person is able to accept his or her thoughts and the fact that they do occur, the process of changing thoughts or behavior patterns may not be quite as difficult. The patient may be less likely to struggle against uncomfortable thoughts or feelings when those thoughts are recognized or validated; and, the patient is more likely to experience long-term change when approaching his or her thoughts and feelings in this manner.\textsuperscript{29} The process is somewhat similar to mindfulness meditation or radical acceptance in approaching problems in that the patient does not run away or avoid problems but instead works to acknowledge them.

A study in the \textit{Journal of Affective Disorders} found that DBT can help to relieve some symptoms and improve self-control among individuals with bipolar disorders type I or type II. The study used the concepts of mindfulness as part of DBT therapy among a group of bipolar patients as part of psychoeducation. The results found that participants showed fewer depressive symptoms, greater mindful awareness, and greater control over their emotions after utilizing DBT.\textsuperscript{30}

When undergoing DBT, a patient may meet with a therapist on an outpatient basis for regular discussion of control of moods and symptoms. The therapist may educate the patient about practicing mindfulness, which involves
becoming conscious of what is happening in the present moment and recognizing current thoughts or feelings based on bodily sensations. The therapist may also discuss how the patient can use DBT techniques to accept his or her own thoughts and feelings and understand that they may not be as big or as complex as they seem. During the session, the patient may also talk about times since the last meeting when he or she was able to recognize and acknowledge thoughts for what they were, rather than acting on them.

Because DBT was originally developed for the treatment of individuals diagnosed with borderline personality disorder, which shares some of the same characteristics of behaviors as bipolar disorder, this method of symptom management can be quite helpful. DBT has also been used successfully for treatment of a substance use disorder when its parameters are slightly adapted. When a person uses drugs or alcohol as a result of intense feelings and emotions, DBT can be used to help the person with accepting his or her thoughts to prevent acting on them and engaging in unhealthy patterns of substance use.

Although not everyone who has problems with bipolar disorder and substance use will experience a complete recovery by using DBT, the program can be successful in helping these patients to develop coping mechanisms and control potentially self-destructive behavior. DBT may also increase a person’s motivation for change, so that if DBT is being incorporated as part of rehabilitation or required treatment, the person may continue to move toward making changes in his or her own thoughts and patterns of behavior. The long-term outcomes associated with DBT have helped many people to experience normal activities and to live more healthy and controlled lives.
Dual Diagnosis Rehabilitation Programs

Some rehabilitation programs are specifically designed to treat those who are struggling with both bipolar disorder and substance use and addiction. These programs integrate treatment of bipolar disorder and substance use by considering the challenges associated with treatment of both conditions and how they affect the other. The patient with a bipolar disorder may need medications for treatment of a related mood disorder and may attend counseling or group support meetings to work on overcoming substance use as well. The advantages of these types of integrated groups are that the patient receives care at the same location that recognizes both disorders, and the caregivers who work in these facilities are typically trained in understanding the treatment of bipolar disorder and co-occurring patterns of substance use without promoting one type of treatment over the other.

Dual diagnosis rehabilitation programs should provide comprehensive services that cover aspects of treatment for both bipolar disorder and its symptoms, as well as the symptoms and complications of substance use. This may include detoxification during the withdrawal phase of recovery from substance use and addiction, medication administration to assist with recovery from substance addiction and to treat the symptoms of bipolar disorder, and counseling through cognitive-behavioral therapy, dialectical behavior therapy, group counseling sessions, or family therapy.

Detoxification involves providing interventions for a person who is undergoing withdrawal from a substance; the interventions are designed to manage the negative effects of withdrawal while the substances are cleared from the body. A patient who is undergoing acute withdrawal symptoms during detoxification may experience tremors and anxiety, as well as some serious complications, such as seizures. It is therefore important in many
cases for a patient to have help from a caregiver or nurse who can provide medications and therapeutic interventions to minimize some of the potentially harmful symptoms of withdrawal. A patient with a bipolar disorder who enters treatment for dual diagnosis with co-occurring substance use may need inpatient care during the detoxification process; while this is an important first step during which the body is cleared of toxins, detoxification alone is not enough as a form of rehabilitation for overcoming the patient’s conditions.

According to the U.S. Department of Health and Human Services, the detoxification process should consist of three components to be considered adequate for treatment: evaluation, stabilization, and fostering patient readiness into treatment.¹⁶ The evaluation phase of detoxification involves assessment of the patient’s condition upon entry into the program. This phase may include determining what substances the patient has been using, drawing blood for laboratory work to determine blood levels of certain substances, and assessing the patient’s physical and emotional condition to determine whether he or she can physically undergo treatment and detoxification and is emotionally prepared and motivated to commit to treatment.

The stabilization phase of the detoxification program includes helping the patient through the physical and psychological difficulties associated with acute withdrawal. The patient may suffer from many negative symptoms and the nurse should be available to provide support, treatment with medications and non-pharmacological interventions to bring the patient into a stable state to where he or she can move forward with treatment. The third step in the process is determining whether the patient is ready to enter treatment for substance use and addiction. At this point, the patient has
overcome many of the physical effects of detoxification and may be ready to learn more about the program that incorporates treatment of substance use and mental health diagnoses. The provider must consider the patient’s needs for care not only of a substance use disorder but must also devise a plan for controlling bipolar disorder symptoms and preventing episodes that will increase the patient’s risks of turning to drugs or alcohol.

A rehabilitation program that manages both co-occurring disorders of bipolar disorder and substance use may have various treatment modalities to use with patients that will help them to work through some of their issues that brought them to treatment in the first place. These treatments, including cognitive-behavioral therapy, dialectical therapy, or group therapy can target the specific issues common to both disorders and provide tools for the affected patient to find success with treatment both within the treatment facility and after discharge back to home.

**Group Therapy**

Group therapy is a useful method of treating patients with a co-occurring bipolar disorder and substance use in a rehabilitation setting. When members of the group struggle with similar symptoms, the group can talk about the effects of depression or mania on their lives among others who will understand and relate. Group settings also can discuss the impact of substance use and addiction on bipolar disorder and their lives in general, regardless of the actual substance(s) being used.

Individuals with bipolar disorder may be more likely to struggle with treatment when dual diagnosis is present. The bipolar illness complicates substance use and addiction treatment to the point that patients with a bipolar disorder tend to heal more slowly, and they require longer periods of
treatment times, receive fewer benefits from going through treatment, and are more likely to commit suicide when compared with patients with other types of mental illness.\textsuperscript{17}

Using a specific type of group therapy to work with patients who have bipolar disorder and co-occurring substance use may help this population who is so prone to struggle during treatment. The National Institute on Drug Abuse (NIDA) has published information about a type of group therapy known as integrated group therapy (IGT) that is designed to focus specifically on these two co-occurring disorders. NIDA conducted a study of patients who were simultaneously diagnosed with bipolar disorder and substance use disorder. The patients in the study had substance use and addiction issues with various types of drugs, including marijuana, cocaine, sedatives, and alcohol. During the IGT sessions, participants talked about their substance use, cravings, and moods related to bipolar disorder. The group facilitators would then discuss topics related to substance use and the varying emotions associated with bipolar disorder and how to handle simultaneous symptoms. The study demonstrated that those who participated in IGT reduced their alcohol and drug intakes and those who achieved abstinence reached the point of abstinence sooner when compared to those who went through standard drug counseling.\textsuperscript{17}

Some of the premise of IGT is the use of cognitive-behavioral therapy, in which the patient with bipolar disorder will consider how one’s moods affect behavior and develop methods for managing emotions during mood fluctuations so that the patient does not turn to substance use. The methods are discussed within the group with information being passed between group members and then counselors who are facilitating the group may further
discuss the situation and provide education about the connections between substance use and bipolar disorder symptoms.

As a form of group therapy, IGT can be a valid option for some patients struggling with co-occurring bipolar disorder and substance use disorder and addiction. Although no singular treatment works for every individual, this type of therapy clearly considers the value of treating both conditions, which can more likely help the struggling patient to manage his or her complex symptoms and to be successful with treatment, and to enjoy an improved quality of life.

*Family Therapy*

Because patients with bipolar disorder have family and friends who are also affected by their illness, family therapy is a helpful method of incorporating these important people into the patient’s treatment so they can provide support and help. Family therapy is also useful to assist family members who may also be struggling with caring for a patient with bipolar disorder; for example, if the person has developed a co-occurring substance use disorder, the family member or caregiver may suffer from intense feelings of guilt, anger, and frustration. Family therapy brings family members together with the patient so that all involved in the relationship can see how certain behaviors and actions affect each other.

Family therapy can take many forms; family members may meet individually with a counselor or therapist who can facilitate positive interactions between the family member and the patient. Group therapy may also be beneficial when more than one family member meets together with the patient and a facilitator who can direct the conversation. Through group therapy, family members can discuss the patient’s treatment goals and the work he or she is
doing through treatment. In this way, family members are familiar with what the patient is working through, such as difficulties with moods and with substance use, the triggers that might cause the patient to turn to drugs or alcohol, and how he or she has learned to cope with interpersonal or situational difficulties.

If the patient is going home after treatment to live with family members, family therapy is also a time where family members develop a plan for living with the patient after discharge or on an ongoing basis. Family members need to be aware not only of the patient’s goals through the recovery process, but also for what to do if the patient has a serious relapse in behavior. For instance, the family members may need to understand which provider to contact if the patient requests help with adapting to medications or when to take the patient to the hospital if his or her behavior is out of control.

Family therapy sessions can provide a method of support similar to a support group, but both the patient and the patient’s family may also benefit from a support group that consists of others outside of the family. Through support groups, family members can meet others who share common experiences of having a loved one who struggle with substance use and addiction and a co-occurring mood disorder. These experiences are often bonding times for family members who must bear the unpredictable and often painful phases of their loved one’s illness.

Inpatient treatment programs used for dual diagnoses of bipolar disorder and substance use and addiction are becoming more common as experts recognize the effects that each condition has on the other and the unique needs of the patients who require treatment. It is extremely common for
patients with substance use disorders and bipolar disorder to experience at least one time of relapse after going through a treatment program. Although a patient may stay at an inpatient center for several weeks and may receive intensive treatment for both conditions through the process, relapse may occur and the patient may need to return or may need to seek outpatient treatment for a longer period.

Many centers that treat patients going through detoxification and withdrawal say that it takes about a month for a patient to break free of the initial bond of addiction, and it takes at least a year before a person feels comfortable without using substance(s). During a time when relapse occurs, a patient may be in great danger of the effects of substances, and many people who relapse are in danger of injury, overdose, or suicide. After undergoing treatment and spending time in sobriety, it can be discouraging and painful for the patient to realize that he or she has relapsed and gone back to using drugs or alcohol again. However, with consistent structure and resumption of a treatment, the patient can get back on track. Often, a patient who undergoes co-occurring substance use and bipolar disorder treatment will have more than one relapse until the patient finally reaches a point where he or she is able to overcome the effects of substance addiction.

**Medications**

Providers working with patients in treatment for dual diagnosis often have options for various prescription medications that can help to control many challenging symptoms. Medication may be administered during the course of treatment to control bipolar disorder symptoms, to manage a substance use disorder, or both. Studies have shown that management of medication for bipolar disorder symptoms, combined with cognitive-behavioral therapy for management of co-occurring substance use with medication for acute
withdrawal symptoms, if needed, is one of the most effective measures to manage both disorders.18

A patient may need to be monitored while receiving certain types of medications and they may be given during inpatient treatment at a rehabilitation facility. Alternatively, some medications are taken less often and can be taken by the patient at home as part of outpatient treatment.

*Bipolar Disorder Medications*

Medications used to treat bipolar disorder can help to normalize moods and prevent drastic swings in behavior and emotions that could lead to substance use. As discussed, antidepressant medications are not the first line of treatment for patients with bipolar disorder, even though they may suffer from bouts of severe depression. Antidepressant use during the depressive cycle of bipolar disorder may cause the patient to experience mania. Instead, clinicians tend to use antipsychotics, anticonvulsants, and mood stabilizer medications to control bipolar disorder symptoms. A helpful website to reference for medication recommendations and selection in the treatment of bipolar disorder is Psycheducation.org, which offers helpful charts of medication types, doses, and other links to research studies and evolving practice to treat bipolar disorder, including addiction related problems.

When a patient with bipolar disorder struggles predominantly with depressive symptoms, there are a number of options for prescription medications that do not include antidepressants. However, there may be some situations when antidepressants are helpful and appropriate for treating bipolar depression and in which patients do not necessarily develop
manic symptoms. Because it may take several weeks for the effects of antidepressants to fully take effect, the patient may or may not experience symptoms right away; the use of these drugs may also require the patient to try more than one type of antidepressant to find the right type of drug that is effective.

The U.S. Food and Drug Administration (FDA) do not approve antidepressants for the treatment of bipolar depression; however, they may be prescribed and have been therapeutic for some people. The drugs that have been found to be most effective in these cases are selective-serotonin reuptake inhibitors (Zoloft®) or selective-norepinephrine reuptake inhibitors (Effexor®). These drugs seem to be more effective in treating bipolar depression and preventing mood swings or rapid cycling when compared to the use of some other forms of traditional antidepressants such as monoamine oxidase inhibitors or tricyclic antidepressants. Additionally, the National Institute for Health and Care Excellence has reported in The Pharmaceutical Journal that fluoxetine can be used effectively for treating bipolar depression, but it is only effective when administered concurrently with an atypical antipsychotic medication such as olanzapine. The combination of these two drugs can work together to control the mood swings between depression and mania that develop with bipolar illness.

Antipsychotics are typically used for the treatment of psychotic mental illnesses such as schizophrenia, but they may also be used for bipolar disorder symptoms. These drugs are often classified as either atypical antipsychotics (2nd generation) or conventional antipsychotics (1st generation). Atypical antipsychotics work slightly differently in the body when compared to standard antipsychotic medications; the conventional antipsychotic medications work by blocking dopamine release while atypical
antipsychotics block dopamine and affect serotonin levels. When a person struggles with co-occurring substance use and bipolar disorder, atypical antipsychotics may work to combat similar symptoms. Because both conditions can affect similar areas of the brain, when a medication is used to regulate an area affected by both disorders, such as dopamine regulation, the affected person may experience relief of both bipolar disorder and substance use symptoms. Atypical antipsychotic drugs are considered to be “newer” when compared to the 1st generation drugs, but they are used for different patient symptoms.

Atypical antipsychotic medications may be used for episodes of mania and for mood stabilization among patients diagnosed with bipolar disorder I. They may also be combined with mood stabilizer medications for treatment of mania or mixed episodes of bipolar disorder. Examples of atypical antipsychotic drugs used in this method include quetiapine (Seroquel®) and risperidone (Risperdal®). Although the FDA has approved these drugs for treatment of mania and mixed episodes, they have not necessarily been approved for specific situations involving bipolar disorder treatment combined with substance use treatment.

Standard antipsychotic medications are helpful in treating episodes of mania, particularly when psychosis is present. They may be successfully used for treatment of hypomania as well. As stated, these drugs work by blocking the neurotransmitter dopamine to relieve psychosis, provide a calming effect for erratic behavior, and relieve agitation. An example of a conventional antipsychotic used for treatment of bipolar disorder is haloperidol (Haldol®).

Anticonvulsant drugs have been shown to be beneficial in treatment of mood swings associated with bipolar disorder, particularly when a patient is
experiencing rapid cycling. These drugs may treat symptoms of mania and some symptoms of depression. Lamotrigine (Lamictal®) is a type of anticonvulsant that helps to control rapid swings in mood and can stabilize mood and behaviors associated with mania, hypomania, and depression. Other anticonvulsant drugs that may be used include carbamazepine (Tegretol®) and topiramate (Topamax®).

Lithium, one of the well-known mood stabilizer drugs, is frequently used in the treatment of bipolar disorder, particularly for calming manic behaviors and emotions. Lithium has also been shown to have a protective effect against suicide and may reduce instances of suicidal ideation among patients with bipolar disorder. Among adolescents who struggle with co-occurring bipolar and substance use disorders, lithium has been shown to be particularly effective. As many as 75 percent of teens and young adults with dual diagnoses have responded to lithium treatment by reducing or eliminating substance use disorder symptoms. As with many other forms of medications used for treatment of bipolar disorder, lithium is not specifically indicated for treatment of bipolar disorder with co-occurring substance use. In other words, it should not be given to prevent or treat substance use disorders among patients who also suffer from bipolar disorder. However, when combined with other forms of treatment for substance use, lithium can be beneficial in stabilizing the moods of the affected patient so that he or she can then use other forms of therapeutic intervention to control substance use.

Medications in the Management of a Substance Use Disorder

In addition to using medications to treat symptoms of bipolar disorder, the patient may need additional medications for management of substance use and addiction. There are several medications specifically designed for
management of substance addiction that can be used alongside bipolar disorder drug treatments during the recovery phase, which include naltrexone and acamprosate. Additionally, some of the medications used to treat bipolar disorder also work for the treatment of a substance use disorder.

Naltrexone is an opioid antagonist drug that has been approved by the FDA for the treatment of substance use, including alcohol and opioid dependence. The mechanism of action of naltrexone in treating an alcohol use disorder is not entirely understood, but it has been shown to reduce cravings for alcohol among patients with addictions. It can be given as an oral tablet or by injection; the injection is an extended-release form that is given once a month and is called Vivitrol®. Naltrexone binds to opioid receptors and blocks them; in this method, it is effective in managing opioid addiction as well. Although naltrexone has been shown to be effective in the treatment of a substance use disorder, it does not necessarily manage bipolar disorder symptoms if the patient does not have a co-occurring substance use problem. A study found in the *Journal of Clinical Psychopharmacology* showed that naltrexone did not have any significant effects on the depressed mood of patients with bipolar disorder who did not have co-occurring substance use. A patient with dual diagnosis may use naltrexone as part of treatment for an addiction disorder, but the drug should not be intended for treatment of bipolar disorder symptoms.

Acamprosate (Campral®) is a drug that may be used for the treatment of alcohol addiction; it has been used to reduce alcohol cravings and may reduce the risk of relapse into alcohol use. Acamprosate may also help to reduce anxiety, sleep problems, and mood swings that can develop when patients undergo alcohol withdrawal. It is safe to use with other
medications and can be used in patients who are going through simultaneous treatment of bipolar disorder. A study in the journal *Bipolar Disorders* demonstrated that acamprosate was tolerated well by users who were receiving treatment for co-occurring bipolar disorder and it does not contribute to worsening of bipolar symptoms.\(^\text{22}\)

Some drugs that have been prescribed for treatment of bipolar disorder may also work as part of treatment for a substance use disorder. Some atypical antipsychotic medications can be helpful when treating substance use disorders because they also treat bipolar disorder mood-related symptoms, and are therefore very beneficial medications for patients with a dual diagnosis. An example of this is risperidone, which is an atypical antipsychotic used to manage neurotransmitter levels among people with bipolar disorder. Risperidone has been used successfully in patients with dual diagnosis for treatment of bipolar symptoms when completing substance use treatment, but it also has been shown to improve care outcomes and may contribute to improved rates of completion of substance use programs.\(^\text{23}\)

**Summary**

The effectiveness of appropriate treatment for co-occurring substance use and addiction disorders and bipolar disorder may vary among patients. Bipolar disorder has been shown to be one of the most difficult mental illnesses to successfully manage, and when combined with a substance use and addiction disorder, the affected patient may struggle through a long trial of treatment regimens before reaching success. While many options are available for treatment, a system of trial and error may be necessary for some patients who may not respond to traditional treatments. The symptoms affiliated with these two disorders can be complex and repeated
relapses can be very discouraging, but when the patient is motivated to change, and by using a system that has been developed to foster positive and specific outcomes, the patient will more likely meet success through treatment and overcome this incredibly challenging situation.

The bipolar disorder spectrum, type I and type II, were reviewed here with an emphasis on how primary psychiatric symptoms are often exacerbated by a co-occurring substance use disorder and addiction diagnosis either during acute treatment, remission, or following a relapse after a period of abstinence from substance use. The bipolar disorder spectrum is presently evolving in the literature with new paradigms that suggest new treatment options during the course of a person’s illness, such as bipolar disorder type III, IV, etc.; however, this topic, worthy of further review, is outside the scope of this study. It’s important for caregivers, patients and their families, to understand evolving medical treatments and available options for treatment specific to the patient’s unique history and circumstances, and to be educated about medication and therapy options that support recovery planning as well as the patient’s chances for success to improve symptom control and quality of life.
REFERENCE SECTION

The reference section of in-text citations include published works intended as helpful material for further reading. Unpublished works and personal communications are not included in this section, although may appear within the study text.


47. Vega, P., et al. (2011, Oct.). Bipolar disorder differences between genders: Special considerations for women: Gender differences in


