Lifelong Learning

Dual Diagnosis of Bipolar and Substance Use Disorders

Abstract

Substance use disorders (SUD) and mental illnesses have many of the same symptoms. Additionally, having a substance use disorder may predispose someone to develop a mental illness and vice versa. Further, those with BD (Bipolar Disorder) and SUD are at increased risk for non-medical use of prescription opioids.

Drug use and addiction can happen at any time during a person's life. SUD typically starts in adolescence, a period when the first signs of BD commonly appear.

Some research has found that mental illness may precede a substance use disorder, suggesting that better diagnosis of youth BD may help reduce comorbidity. One study found that adolescent-onset BD confers a greater risk of subsequent SUD compared to adult-onset BD.

There appears to be genetic associations between BD and SUD.

BD and SUDs share common neurobiological pathways and behavioural sensitisation (eg, "kindling") may be a common mechanism. Repeated exposure to alcohol and drugs sensitises neurons and is associated with increasingly rewarding effects.

Thirdly, certain traits associated with BD may elevate the risk for patients to engage in substance use. These include impulsivity, poor coping strategies for stress and excessive pleasure-seeking associated with the manic or hypomanic phases of the illness.

An alternative explanation for co-occurring BD and SUDs is the self-medication hypothesis, which proposes that patients use substances to help alleviate BD symptoms.

Assessment and diagnosis

Assessment and diagnosis of patients with co-occurring BD and SUDs can be challenging for a number of reasons. First, bipolar illness itself is a heterogeneous disorder with different subtypes and presentations.

Second, symptoms of alcohol and drug intoxication and withdrawal may resemble BD symptoms, making it often difficult to distinguish between the two. Symptoms of withdrawal (eg, depression, dysphoria, sleep difficulties) also parallel BD symptoms in the depressed or mixed phases.

Patients entering treatment for psychiatric illnesses should be screened for substance use disorders and vice versa. Similarly, when people who use drugs enter treatment, it may be necessary to observe them after a period of abstinence to distinguish between the effects of substance intoxication or withdrawal and the symptoms of comorbid mental disorders.

Misdiagnosis

BD is most often misdiagnosed in its early stages, which is frequently during the teenage years. Other factors of a misdiagnosis are inconsistency in the timeline of episodes and behaviour. Most people don't seek treatment until they experience a depressive episode

According to a study published in *Psychiatry Trusted Source*, around 69% of all cases are misdiagnosed. One-third of those aren't properly diagnosed for 10 years or more as the condition shares many of the symptoms associated with SUD and other mental disorders.

Similarly, many SUD patients are misdiagnosed with BD. The stigma associated with SUD also contributes to the acceptance of this misdiagnosis.

Treatment

Diagnosis is the first challenge in the care of patients with co-occurring BD and SUD. Finding effective treatment is arguably just as challenging. Although there is no one single optimal treatment strategy, the management of these co-occurring disorders should integrate both pharmacological and psychosocial interventions.

Monitoring and continuum of treatment is essential. Regular re-assessments and modification of treatment strategies are integral to successful treatment.