MENTAL HEALTH AND SUBSTANCE USE:

DUAL DIAGNOSIS - BIPOLAR DISORDER AND SUBSTANCE USE TREATMENT

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Abstract

Co-occurring bipolar disorder and substance use disorder pose a serious health risk to affected individuals. Patients with dual diagnoses may experience substantial challenges during treatment for their mental illness and recovery from substance use. Early diagnosis and intervention can significantly improve the potential outcomes for patients with a dual diagnosis. The changes made in this area within the Diagnostic and Statistical Manual of Mental Disorders guide health clinicians managing bipolar disorder complicated by a substance use disorder to lower the health risks throughout the age spectrum.

Policy Statement

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This educational activity is credited for 2.5 hours at completion of the activity.

Statement of Learning Need

Health professionals need to be alert to the possibility of a dual diagnosis of bipolar disorder and substance use disorder to be able to provide each patient with the most appropriate and individualized treatment options.

Course Purpose

To provide health clinicians with knowledge about diagnosing a comorbid condition and the new criteria in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) that help guide treatment for bipolar disorder and substance use disorder.

Target Audience

Advanced Practice Registered Nurses, Registered Nurses, and other Interdisciplinary Health Team Members.

Disclosures

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Self-Assessment of Knowledge Pre-Test:

1. **Dialectical behavior therapy (DBT) is a method of therapeutic intervention that helps a patient**

    a. understand that the patient's thoughts do not have meaning.
    b. recognize how thoughts and emotions affect behavior.
    c. accept negative thoughts as they are.
    d. change how the patient thinks.

2. **A patient who is guided during therapy to understand that the patient is not defined by his or her thoughts is involved in**

    a. dual diagnosis rehabilitation.
    b. cognitive-behavioral therapy (CBT).
    c. dialectical behavior therapy (DBT).
    d. integrated group therapy (IGT).

3. **Which of the following statements is true about prescribing antidepressants for patients with bipolar disorder?**

    a. Antidepressants are usually the only medication option for treating patients with bipolar disorder.
    b. Antidepressant medications are NOT the first line of treatment for patients with bipolar disorder.
    c. Antidepressant medications prevent cycling between depression and mania.
    d. There are really no situations in which antidepressants should be used to treat a patient with bipolar disorder.

4. **_____ is an opioid antagonist drug that has been approved by the FDA for the treatment of substance use, including alcohol and opioid dependence.**
    a. Lithium
    b. Topiramate
    c. Naltrexone
    d. Lamotrigine

5. **The most effective approach for treating substance use disorders that occur with a bipolar disorder is to treat**
    a. the bipolar disorder first.
    b. the substance use first.
    c. each disorder separately.
    d. both conditions at the same time.

Introduction

The treatment of bipolar disorder symptoms are complicated in the setting of a substance use disorder. When a patient has a co-occurring substance use, the treatment plan for bipolar disorder must be developed that addresses both conditions. In order to develop a treatment plan, clinicians should consider factors such as the possibility of symptom relapse, the severity of symptoms, overlap of symptoms between different disorders, and the age of the patient. A clinician may choose between behavioral approaches to treatment such as behavioral therapy, medication treatment, or a combination of both. Dual diagnosis rehabilitation programs are useful in this context because they recognize and deal with substance use disorders and bipolar disorders at the same time. After a treatment plan is chosen, a successful outcome and rehabilitation will not happen unless a patient engages in and adheres to the treatment plan.

Challenges to Treating a Bipolar Disorder

Bipolar disorder is one of the most difficult mental health issues to consistently treat even when substance use is not present. Substance use disorders that occur with bipolar disorder complicate the treatment of bipolar disorder even more. This complexity arises for various reasons. To begin with, a treatment plan must be developed that addresses a patient's particular circumstance such as the presence of comorbidities and the severity of the patient's symptoms. In addition, when substance use is present, patients often have difficulty adhering to treatment regimens, which leads to decreased compliance. This is not surprising since substance use disorder in patients who have bipolar disorder is associated with a comparatively high use of a substance. Complications also arise since patients with bipolar disorder and concomitant substance use have an increased risk for suicide, high levels of functional impairment, decreased quality of life, and delayed recovery from symptomatic episodes.[1-3]

Developing a Treatment Plan

Historically, bipolar disorder and substance use disorder in a patient 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 through alcohol or drug rehabilitation programs. This approach would help a patient control a mental illness or substance use diagnosis but it usually fell short in addressing the combined effects of both disorders. Experts now maintain that treatment of bipolar disorder and a substance use disorder, or a "dual diagnosis", requires that a dual diagnosis be specifically managed in order to provide comprehensive care and to improve the likelihood of symptom control of both conditions.[4,5]

Factors Affecting Treatment

There are aspects that a clinician will want to consider when developing a treatment plan for a dual diagnosis. It is important to consider the possibility of the patient relapsing, the severity of the patient's symptoms, overlap of symptoms between different disorders, and the age of the patient.[4-10]

Relapses

A patient may relapse into substance use because of bipolar-related symptoms, which can be stigmatizing to the patient. Clinicians should guide the patient and family or significant others to not perceive the relapse as a failure, but rather as a chance to work through more of the patient's mental health concerns, such as environmental triggers or difficulties with maintaining a sobriety program related to drug and alcohol use.[4-10] 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 to achieve success.

Severity of Symptoms

The extent of symptoms related to a bipolar disorder may range from being mild to severe and are related to the frequency of manic and depressive

episodes, and possibly rapid cycling. As mentioned, a substance use disorder can complicate treatment when the bipolar disorder is severe. Without proper treatment of a bipolar disorder, a patient is at risk of behavior with potentially serious consequences, such as the risk of suicide, that can occur during both manic and depressive episodes.[4-10] Untreated substance use causes further problems, such as putting the patient at risk of injuries or death from uncontrolled behavior while intoxicated, as well as chronic medical problems from the toll that the drugs or alcohol have 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 rapid cycling or frequent episodes are not occurring.[4-10] Through treatment, patients can learn to manage their symptoms during manic or depressive episodes, but also to control substance use to avoid developing chronic substance use. Substance use disorder 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.

Overlap of Symptoms

Treatment of co-occurring bipolar disorder and a substance use disorder can be difficult, as many of the symptoms associated with each condition may overlap. It may be difficult to determine which condition is causing specific symptoms.[4-10] Furthermore, if a patient with bipolar disorder is not properly diagnosed and seeks treatment for substance use, it may appear that the person is not responding to treatment if the unmanaged symptoms of bipolar disorder continue to manifest.

Patient Age

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 may be struggling significantly with mood changes and difficulties with thoughts and behaviors, including cravings for substances that lead the individual to search for more.[9,10]
Treatment of adolescents has been most successful after early intervention. When parents recognize a problem in their child at the start of noticing behavior changes, such as a rise in impulsivity or poor judgement, early interventions to get the adolescent into treatment can be effective. Teens who respond to dual diagnosis treatment programs often do so with initiation of therapeutic interventions that include psychoeducation, helpful information about substances and their negative and harmful effects on a person, use of medications to help control moods, and close monitoring.[9,10]

The type of treatment and its delivery depend on the patient's condition and other factors that are specific to the patient's unique situation, such as age, the presence of other physical or mental illnesses, and the amount of family support available.[9,10] 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.

Psychotherapy is recommended as an adjunct to pharmacotherapy for pediatric bipolar disorder. The intensity of psychotherapy will increase based on the child/adolescents severity of symptoms. The sessions held during the week or month will range and may involve inpatient or intensive outpatient clinic settings.[10] If a patient is too psychotic to engage in therapy then psychotherapy may be delayed until the patient can respond coherently and comprehend treatment enough to provide informed consent.

First line treatment for pediatric bipolar disorder includes psychoeducation in combination with pharmacotherapy. Randomized trials suggest that psychoeducation in combination with medication improves primary symptoms of bipolar disorder than medication alone.[10] Three sessions of psychoeducation with 21 sessions of family psychotherapy in adolescents treated with medication for a diagnosis of bipolar disorder were found to recover from a mood episode and mood cycles (relapses) than treatment without psychoeducation regardless of differences in therapy sessions.[10]

Children and adolescents who do not respond to psychoeducation may do better in family therapy. Research that compared family therapy to psychoeducation reported there was benefit found in the patients involved in family therapy that included reduction of bipolar disorder symptoms. Family therapy may also be added to pharmacotherapy as well as other therapy options, such as cognitive behavioral therapy (CBT) and dialectical behavioral therapy (DBT).[10]

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 behavioral therapy may be more successful as these approaches involve the patient and the health clinician working together toward positive outcomes early on that may be more likely to result in a successful outcome. The following sections will discuss behavioral therapeutic approaches that may be implemented.

Cognitive and Dialectical Behavioral Therapy

In addition to psychoeducation and family therapies raised previously, other helpful adjunctive psychotherapy for bipolar disorder in all age groups includes cognitive behavioral therapy (CBT) and dialectical behavioral therapy (DBT) to assist patients and families recognize prodromal symptoms (early warning signs) and to overcome the stigmatism of having a bipolar disorder. Individuals who engage in adjunctive psychotherapy should be

encouraged to continue therapy after achieving a euthymic state. Adjunctive therapies for bipolar disorder can be administered in an individual and group format.

Cognitive Behavioral Therapy

Cognitive-behavioral therapy is a therapeutic process that has been shown to be helpful for patients with bipolar disorder, decreasing the relapse rate and improving depression symptoms, the severity of mania, and improving social functioning. The method is often used in treating symptoms of depression, anxiety, and some other types of mood disorders, including the management of bipolar disorder. Cognitive-behavioral therapy is a method that teaches a patient to recognize how thoughts and emotions affect a person's behavior.[11-14] Often, a person who struggles with a mood disorder can have self-destructive thoughts that lead to inappropriate behavior due to internal thoughts and negative perceptions of the self and of others. The cognitive aspect of CBT involves thought recognition, while the behavioral aspect works to change behavior based on changing thought processes.

A patient with bipolar disorder may act on feelings and thoughts whether they are true or not. The patient may enter a depressive episode, feel guilty and hopeless, and may decompensate further into depression due to environmental stressors, such as a negative encounter at home or work. Negative feelings that may ensue from environmental stress may lead the patient to use alcohol or drugs to feel better. Through working with a therapist and processing these responses to external triggers, the patient may realize that substance use is a temporary way of feeling better by self-medicating in response to negative feelings.[11-14] Through therapy the patient can recognize how negative thoughts contribute to behavior.

Patients are guided during CBT 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 are not defined by their 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.[11-14] 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 the thoughts that are negative or disturbing, so that intervention may be sought before engaging in harmful activities or behaviors in a reaction to those thoughts. Therapists often work with patients to help them recognize that thoughts are simply thoughts and they do not have to control a person's choice of 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 mental health clinician who is treating a patient with a bipolar disorder may use CBT to help the patient develop a set of goals for the patient to 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 feeling a manic episode coming on and work to change behaviors to stay safe.[11-14] 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 can better recognize warning signs and redirect thoughts and behaviors to avoid a relapse.

For the patient who is struggling with a co-occurring disorder, CBT can be beneficial to determine how substance use plays into the patient's responses to internal 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 see how to challenge thoughts and to avoid turning to drugs or alcohol during difficult circumstances.

The process of using CBT for the management of bipolar disorder and substance use 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.[11-14] The patient and the therapist meet regularly to review the patient's work toward thought recognition, and the patient may

also have treatment assignments between learning sessions to recognize how thoughts can affect behavior and to keep track (possibly through a personal journal or manualized approach/diary) of those times. Through such steps the patient may learn to perform what is required during recovery to manage 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 therapy outcomes. CBT tends to be more goal-directed, and involves specific problem solving to help the patient manage and recover from mental illness, as compared to 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 to be as effective as antidepressants for some people who have struggled with major depressive disorder.[11-14]

Clearly, cognitive behavioral therapy 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. Cognitive-behavioral therapy 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 Behavioral Therapy

Dialectical behavior therapy is a method of therapeutic intervention that may be utilized for the management of symptoms of a bipolar disorder and co-occurring substance use disorder. It was first developed by Marsha Linehan as a method of expanded CBT 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. Dialectical behavior therapy 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 mental illness.[15-18]

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 individuals are able to accept their own thoughts, the process of changing thoughts or behavior patterns may not be quite as difficult.[15-18] 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 thoughts and feelings in this manner. 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.

There is not a large amount of research on the use of DBT for patients who have bipolar disorder, but some recent studies on psychosocial interventions for bipolar disorder suggest that DBT, alone or with other interventions, has been shown to be effective at reducing depressive symptoms in this patient population.[15-18] When undergoing DBT, a patient may meet with a therapist on an outpatient basis for regular discussion of mood and symptom control. 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.[15-18] The patient is guided by the therapist to use DBT techniques to accept internal thoughts and feelings and to understand that these thoughts are not as complex as they seem. The patient may actually begin to recognize moments between sessions of being able to recognize 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 (sharing some of the same characteristics as bipolar disorder), this method of symptom management can be quite helpful. Dialectical behavior therapy has also been used successfully for the treatment of a substance use disorder.[15-18] When a

person uses drugs or alcohol as a result of intense feelings and emotions, DBT can be used to help the person to accept internal thoughts to prevent acting on them and avoid engaging in unhealthy patterns of substance use.

Although not everyone who has problems with bipolar disorder and substance use will experience complete recovery by using DBT, the program can be successful in helping these patients to develop coping mechanisms and to control potentially self-destructive behavior. Dialectical behavior therapy may also increase a person's motivation for change, so that if DBT is being incorporated as part of rehabilitation or required treatment, there may be ongoing progress made to change or transform ways of thinking and patterns of behavior.[15-18] 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 bipolar disorder and a substance use disorder. 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 symptom, such as irritability or anger, and may attend counseling or group support meetings to work on overcoming cravings to use drugs or alcohol. The advantages of these types of integrated groups are that the patient receives care for a dual disorder at the same location, and the health teams 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.[19-21]

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. In addition to CBT and DBT, dual diagnosis rehabilitation may include detoxification during the acute withdrawal phase of recovery from a

substance, group therapy sessions, or family therapy. This section will address detoxification, group therapy, family therapy, and medication management will be discussed last.[19-21]

Detoxification

Detoxification involves providing interventions for a person who is undergoing withdrawal from a substance, and the interventions are designed to manage the negative effects of withdrawal while the substances are cleared from the body. Patients who are 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 health team member 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.

The detoxification of a patient who has a substance use disorder begins with an evaluation of the severity of the disorder and addressing any medical or psychiatric issues that are immediate threats to the patient's health and safety. The next step is medically supervised withdrawal, and then followed by continuing care. 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 health clinician must consider the patient's unique treatment needs for a dual diagnosis and for the prevention of mood episodes and relapses that increase the patient's health risks.

A rehabilitation program that manages 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 can target the specific issues common to both disorders and provide specific 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 allow for discussion of the impact of substance use on bipolar disorder and the lives of individuals in general, regardless of the actual substance(s) being used.

Individuals with a dual diagnosis may be more likely to struggle with treatment. The symptoms of bipolar disorder complicate substance use treatment to the point that patients tend to heal more slowly, and they require longer periods of treatment, receive fewer benefits from going through treatment, and are more likely to commit suicide when compared to patients with other types of mental illness. 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. The NIDA conducted a study of patients who were simultaneously diagnosed with bipolar disorder and substance use disorder, and the patients in the study had substance use issues with various types of drugs, including cannabis, cocaine, sedatives, and alcohol. During the IGT sessions, participants talked about their substance use, cravings, and moods related to bipolar disorder. The group facilitators then discussed 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 intake and those who achieved abstinence reached the point of abstinence sooner when compared to those who went through standard drug counseling.

One aspect of IGT is the use of cognitive-behavioral therapy, in which the patient with bipolar disorder will consider how mood states affect behavior. The patient may then 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. 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 complex symptoms and to be successful with treatment.

Family Therapy

Because patients with bipolar disorder have family and friends who are also affected by their mental illness, family therapy is a helpful method of incorporating important family members 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 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 being done through treatment. In this way, family members are familiar with what the patient is working through, such as difficulties with mood and with substance use, the triggers that might cause the patient to turn to drugs or alcohol, and how the patient 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 health clinician or therapist to contact if the patient requests help with adapting to medications or when to take the patient to the hospital if 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 struggles with substance use 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 mental illness.

Relapse Following Treatment

Inpatient treatment programs used for dual diagnoses of bipolar disorder and substance use 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 highly common for patients with substance use and bipolar disorder to experience at least one episode 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.

The general medical wisdom is that dual diagnosis programs lead to more favorable outcomes for patients with comorbid mental health and substance use diagnoses. Dual diagnosis capable programs have been reported to admit and treat patients with severe symptoms, however the benefit achieved from a dual diagnosis treatment program remains a focus of study. Researchers have suggested that future studies evaluating discrepancies in a dual diagnosis treatment program are needed to possibly identify future more efficient programs.[21] Efforts made to integrate services and systems to treat people with a dual diagnosis suggest that improvement in such services are needed. Currently, an estimated 18% of substance use disorder treatment programs and 9% of mental health treatment programs were dual diagnosis capable, which indicated that patients and families seeking services have a 1 in 10 to 2 in 10 chance that both disorders will be safely and appropriately addressed. Such data suggests that gaps in care still exist and that improvement in the system persists.[21]

Many centers that treat patients going through detoxification and withdrawal say that it takes at least a year before a person feels comfortable without using substance(s), and the level of craving substances is unique to each individual. During a time when relapse occurs, a patient may be a high risk of the effects of substance use, and many people who relapse are in danger of injury, overdose, or suicide. An estimated 40 to 60 percent of individuals receive treatment for a chronic or relapsing substance use disorder, and often have co-occurring mental health, physical health and social problems that require a multidisciplinary approach to treatment.[22]

After undergoing treatment and spending time in sobriety, it can be discouraging and painful for the patient to encounter a relapse and to resume 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 finally reaching a level of meaningful progress.

Medication Treatment for Dual Diagnosis

Health teams working with patients in treatment for a dual diagnosis have options to treat and to control many challenging symptoms. Medications 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, combined with cognitive-behavioral therapy for the management of co-occurring substance use, is one of the most effective measures to manage both disorders.

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

Medications Types to Manage Bipolar Disorder

Medications used to treat bipolar disorder can help to normalize moods and to prevent drastic swings in behavior and emotions that could lead to substance use. 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. The use of antipsychotics and anticonvulsants for mood stabilization to control bipolar disorder symptoms is generally preferred. 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 in the treatment of bipolar disorder.

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 for the best effect.[23,24]

There are many pharmacologic options for treating depression in patients who have bipolar disorder.[25] During the acute treatment phase, lithium, lamotrigine, fluoxetine/olanzapine combination, and the second generation antipsychotics lurasidone and ziprasidone are examples of medication that have all been shown to be effective.[25,26]

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 (second generation) or conventional antipsychotics (first 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.[26] 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 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 like lithium or valproic acid for treatment of mania or mixed episodes of bipolar disorder.[26]

Examples of atypical antipsychotic drugs used in this method include quetiapine (Seroquel) and risperidone (Risperdal). Although the Food and Drug Administration (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.[26]
Standard antipsychotic medications are helpful in treating episodes of mania, particularly when psychosis is present. They may be successfully used for the 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.[26] An example of a conventional antipsychotic used for the treatment of bipolar disorder is haloperidol (Haldol).

Anticonvulsant drugs have been shown to be beneficial in the 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 stabilize depression. Other anticonvulsant drugs that may be used include carbamazepine (Tegretol) and topiramate (Topamax).[27] 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.[28] Among adolescents who struggle with co-occurring bipolar and substance use disorders, lithium has been shown to be particularly effective.

The added morbidity associated with substance use disorders (SUDs) in the setting of a bipolar disorder is a major public health cost and concern. Because substance use adversely affects treatment outcomes, clinicians are confronted by multiple issues related to slower remission, increased mood episodes and decreased quality of life for patients and families. There is a higher rate of non-adherence to medication to treat a bipolar disorder when substance use is involved.[29] Lithium use in individuals with a co-occurring

substance use disorder has been found to be ineffective for an estimated 40% of patients. Lithium nonresponse in mood rapid cyclers with substance use has been reported. In such cases, divalproex (an anticonvulsant mood stabilizer) has efficacy to treat acute bipolar mood episodes in the setting of substance use.[29]

As with many other forms of medications used for the 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 for mood stabilization in the affected patient so that other forms of therapeutic intervention may be used to control substance use.

Medication Types to Manage Substance Use Disorder

In addition to using medications to treat symptoms of bipolar disorder, the patient may need additional medications for the management of a substance use disorder. There are several medications specifically designed for the management of substance use 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 use. 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 an alcohol use disorder.[30-33] 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 use 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, and when used to treat patients who have bipolar disorder and alcohol use disorder, naltrexone has been effective at reducing some of the craving and the number of drinking days, but no better than placebo for reducing depressive and mania symptoms.[30-33] A patient with dual diagnosis may use naltrexone as part of treatment for substance use, but the drug should not be intended for the treatment of bipolar disorder symptoms.

Acamprosate (Campral) is a drug that may be used for the treatment of alcohol use disorder, and it has been used to reduce alcohol cravings and may reduce the risk of alcohol use relapse. It is safe to use with other medications and can be used in patients who are going through simultaneous treatment of bipolar disorder. There is only a small amount of research on the use of acamprosate in patients who have a dual diagnosis and the results have not been encouraging. In the majority of patients in the research studies acamprosate was no more effective than placebo.[31-33]

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 for the treatment of 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, but it also has been shown to improve care outcomes and may contribute to improved rates of completion of substance use programs.[30-33]

Adherence to Treatment

A treatment plan is only effective if the patient adheres to the plan. Adherence is a word used to describe a patient's willingness to cooperate with directions from the mental health clinician. A patient's adherence to treatment indicates that he or she is cooperative and willing to follow the recommendations as given by the clinician working with the patient. This

may include taking medications as prescribed, attending therapy sessions, or completing manualized assignments as part of a behavior plan, such as cognitive and dialectical behavioral therapy.

Many different risks are involved in determining how a patient will respond to treatment. They are complex and they vary between individual circumstances. Some of these factors include a poor relationship between the patient and the clinician, 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.

This section highlights some of the issues impacting successful treatment of a dual diagnosis identified in some of the current research.[34-36]

Abstinence

A person abstaining from alcohol or drugs will undergo symptoms associated with withdrawal. The physical discomforts effects of withdrawal are often uncomfortable. This may lead to a greater lack of adherence to the treatment plan by the patient because the patient wants to remove the discomforts the patient is feeling. These patients need to be monitored closely during the detoxification process.

When a person is undergoing symptoms of withdrawal, there may be triggers leading to a mood episode. This causes further difficulties if the patient suffers from manic symptoms at the same time.

Mental Illness and Adherence

A manic episode is characterized by erratic behavior that causes a person to be revved up in energy and activity. 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. They are at a much higher risk of treatment non-compliance

and poor treatment responses. This is true of patients with a current substance use disorder or a past history of substance use.

If the patient receives medication as a prescription, the patient 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 use 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, the patient may be having feelings of grandiosity or expansiveness and may not feel the need to take medication and subsequently refuse to take it.

Even among those patients with bipolar disorder who are 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, and it has been reported that up to 65% of patients who have bipolar disorder do not conscientiously and routinely take their medications.[32] 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.

A patient diagnosed with co-occurring bipolar disorder and substance use may decide to stop taking therapeutic medications during a period of mood dysregulation or a manic phase because the drugs are felt to not be working. Patients who are going through a cycle of depression or mania while on medication may impulsively alter or forget to take their medication. Other reasons for non-adherence include an inability to tolerate the side effects of medication and disturbances of cognitive functioning that may develop as a result of taking the medications.

Some patients do not adhere to their treatment plan because they do not appreciate the effects of their medications as part of the treatment of bipolar disorder. A patient may experience a calm and stable mood because of taking a prescribed medication but may also no longer feel like his/her

"normal" self. Furthermore, some patients may develop anxiety about drug effects or over-analyze drug use to the point that they no longer want to take medications. Studies have shown that some non-adherence to medication regimens has multiple causes, and may include a longer duration of treatment, fear of side effects, and a past history of non-adherence.

Patients who have co-occurring substance use disorders and 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.

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 incorporate cognitive-behavior interventions, the patient may have difficulty 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 difficulty showing up to scheduled appointments. These responses stem from some of the major symptoms of mania that cause feelings of grandiosity, in which a patient may believe attendance at therapy has gone so well that continuing treatment 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.

When considering the effects of treatment on a patient experiencing mania, the clinician may need to provide the patient with different options that are more likely to promote adherence to the treatment plan. For instance, a patient experiencing mania may benefit from inpatient treatment for a substance use disorder, since inpatient treatment would allow the patient to be monitored more closely until manic symptoms lessen. A system of close

monitoring of a patient's behavior and responses to treatment if the patient is manic may more likely provide success in implementing therapeutic treatment during an acute episode.

Depressive Episode and Adherence

The demands of treatment can be challenging 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 challenging when considering that the patient has acute symptoms of depression and may struggle with completing tasks and adhering to the program.

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 severe symptoms; however, they may struggle significantly with a substance use disorder, 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. The patient 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 because of a fear of drug side effects. Some patients do not appreciate the effects of the drugs because of the time it takes for the medications to take effect or because of 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 treatment is at great risk of not only the harmful effects of substance use, but of other factors related to depressive symptoms. For example, failure to comply and to avoid taking medications or attending treatment raise barriers to resolving many depressive symptoms, causing the patient to continue to struggle. The patient may drink alcohol or use drugs to combat some uncomfortable feelings, which can further perpetuate substance use and physical craving, 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.

A Multi-system Approach

In cases where a patient is struggling to adhere to treatment regimens because of having a bipolar disorder, a multi-system approach is often more successful than one single treatment. This involves not only treating the bipolar disorder and the substance use disorder but 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 CBT and medication, as each may support the other. The patient may have trouble taking medication on time, but through CBT may have a better chance of remembering to take medication or to work through issues of non-compliance.

Case Study: Dual Diagnosis and Recovery

The following case studies were obtained from a PubMed search and describes a case of a 64-year-old male with 40 years of chronic alcohol use and bipolar disorder.[37]

The authors reported the patient in this case had a psychiatric and alcohol use history that included six hospital admissions a year with alcohol-related problems over a minimum of a 10-year period. He had thought about reducing his alcohol intake. He reportedly had mood disturbances and he was followed by a psychogeriatrician who diagnosed him with bipolar disorder.

Various medications for bipolar disorder were trialed, which included lithium and sodium valproate however these did not prove successful. The patient was started on quetiapine 600 mg a day in divided doses. He was prescribed quetiapine high dose of 200 mg three times a day. The patient's daily alcohol intake dropped from 30 units/day to negligible amounts of alcohol after initiating quetiapine. Between 2009 and 2012, there were no further alcohol-related hospital admissions. Eventually, the dose of quetiapine was reduced from 600 mg/day to 300 mg daily.

Laboratory testing showed that his γ-glutamyl transpeptidase (GGT) has fallen from 1699 (8/2009), 1102 (4/2011) to 914 (9/2012).

This medication regimen was reported to control the patient's bipolar disorder and also resulted in significant reduction in alcohol intake. The authors stated that the patient began to share a bottle of wine with his wife while previously he was reported to consume a bottle of scotch daily. Ultrasound of the abdomen showed coarse echotexture without focal lesions. Spleen was enlarged at 14 cm. Gallbladder and kidneys were normal. α-Fetoprotein was 4.4. Liver function showed alanine transaminase 29, alkaline phosphate 124, GGT 914, albumin 42, bilirubin 15 (September 2012).

He was started on quetiapine 600 mg/day for 1 year and then reduced to 300 mg/day. The patient did not respond to common medications for bipolar disorder such as lithium and sodium valproate.

The authors stated that this case is an example of the benefits of quetiapine to assist with addiction to alcohol. They discussed that "alcohol and alcohol-related presentations are an ever increasing health burden"... and they stated that there are many different methods of addressing alcohol use including hospital detox units and pharmacological therapies such as disulfiram and benzodiazepines.[37]

Discussion

The authors reported that quetiapine is widely used in the treatment of bipolar disorders and was approved by the Food and Drug Administration in 2006 to be used as monotherapy. Quetiapine and risperidone had been reported in patient studies to reduce drug cravings as compared with a patient's baseline.

Quetiapine had also been studied specifically for its effect on alcohol craving. The authors cited a retrospective study of 30 patients with alcohol use problems that received quetiapine (20–200 mg every night) for disturbed sleep. The results of this study showed "quetiapine improved sleep disturbance and may help in alcohol reduction and maintaining abstinence".[37] The authors also raised that prior studies had shown quetiapine improves response inhibition in alcohol use, and of the benefits of quetiapine in the treatment of substance use disorders in general. They stated that it appeared uncertain whether quetiapine has a direct effect on alcohol reduction or through controlling the symptoms of bipolar disorder.

The authors highlighted that the cause of alcohol use disorder is multifactorial. Stress at work and with relationships, binge drinking, and mental illness can all lead to an alcohol use problem over time. Alternatives to benzodiazepine use may include quetiapine, which the authors indicated

should be considered in patients with a diagnosed bipolar disorder and mood disturbance.

There have been several pilot studies that have already shown the benefits of quetiapine in alcohol use disorder, according to the authors, including several completed studies. For example, there is a study on the combined therapy of quetiapine with mirtazapine to quetiapine monotherapy for the treatment of alcohol use. Future studies are needed and clinicians will benefit in their management of patients with comorbid substance use and bipolar disorder by reviewing the varied phases and final findings of the existing study trials that have been conducted.

Summary

The effectiveness of the current treatment for co-occurring substance use 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 disorder, the affected patient may struggle through a long trial of treatment regimens before reaching success. While many treatment options are available, a process of trial and error may be necessary for some patients who may not respond to traditional treatments. The symptoms associated with a dual diagnosis can be complex and repeated relapses are not uncommon, which can be very discouraging for the patient and family. However, when the patient is motivated to change by using a treatment program that has been developed to foster positive and specific outcomes, the patient will more likely meet success through treatment and overcome a very difficult and challenging situation.

Self-Assessment of Knowledge Pre-Test:

Please take time to help NurseCe4Less.com course planners evaluate the nursing knowledge needs met by completing the self-assessment of Knowledge Questions after reading the article, and providing feedback in the online course evaluation. Completing the study questions is optional and is NOT a course requirement.

1. **Dialectical behavior therapy (DBT) is a method of therapeutic intervention that helps a patient**

    a. understand that the patient's thoughts do not have meaning.
    b. recognize how thoughts and emotions affect behavior.
    c. accept negative thoughts as they are.
    d. change how the patient thinks.

2. **A patient who is guided during therapy to understand that the patient is not defined by his or her thoughts is involved in**

    a. dual diagnosis rehabilitation.
    b. cognitive-behavioral therapy (CBT).
    c. dialectical behavior therapy (DBT).
    d. integrated group therapy (IGT).

3. **Which of the following statements is true about prescribing antidepressants for patients with bipolar disorder?**

    a. Antidepressants are usually the only medication option for treating patients with bipolar disorder.
    b. Antidepressant medications are NOT the first line of treatment for patients with bipolar disorder.
    c. Antidepressant medications prevent cycling between depression and mania.
    d. There are really no situations in which antidepressants should be used to treat a patient with bipolar disorder.

4. _____ is an opioid antagonist drug that has been approved by the FDA for the treatment of substance use, including alcohol and opioid dependence.

a. Lithium
b. Topiramate
c. Naltrexone
d. Lamotrigine

5. The most effective approach for treating substance use disorders that occur with a bipolar disorder is to treat

a. the bipolar disorder first.
b. the substance use first.
c. each disorder separately.
d. both conditions at the same time.

6. A patient who is manic exhibits erratic behavior that causes the patient

a. to be revved up in energy and activity
b. to be lethargic and have feelings of low self-worth.
c. to lose contact with external reality.
d. to have overlapping symptoms.

7. One of the key factors that complicates treating substance use disorders that occur with a bipolar disorder is that

a. symptoms of each disorder may overlap.
b. the symptoms of each disorder are universally different.
c. both conditions cannot be effectively treated in an outpatient setting.
d. the treatments for each disorder are so different that they cannot be treated together.

8. Cognitive-behavioral therapy is a method that teaches a patient to

a. acknowledge and accept negative thoughts.
b. recognize and immediately change negative thoughts.
c. recognize how thoughts and emotions affect a person's behavior.
d. acknowledge that behavior patterns are not difficult to change.

9. True or False: A cognitive-behavioral therapy (CBT) therapist may help a patient understand that thoughts are simply thoughts and they do not have to direct a person's behavior.

a. True
b. False

10. Dialectical behavior therapy (DBT) was originally developed to treat patients with

a. substance use disorders.
b. psychosis.
c. bipolar disorder.
d. borderline personality disorder.

11. One aspect of integrated group therapy (IGT) is the use of _____, in which the patient with bipolar disorder will consider how his or her moods affect behavior.

a. detoxification programs
b. cognitive-behavioral therapy (CBT)
c. dialectical behavior therapy (DBT)
d. comprehensive care

12. One of the most effective measures to manage bipolar and substance use disorders is to use medications to manage the bipolar disorder and _____, and cognitive-behavioral therapy (CBT) to address the co-occurring substance disorder.

a. acute withdrawal symptoms
b. the patient's negative feelings of low self-worth
c. change a patient's behavior
d. control a patient's negative thoughts

13. Standard antipsychotic medications are helpful in treating episodes of mania, particularly when

a. a patient is being detoxified.
b. a patient has negative feelings of low self-worth.
c. psychosis is present.
d. a patient is experiencing rapid cycling.

14. True or False: Anticonvulsant drugs should not be used in bipolar patients who are experiencing rapid cycling.

a. True
b. False

15. In a patient who has co-occurring bipolar disorder and substance use disorder, lithium can be beneficial

a. to detoxify the patient from the drug(s) that the patient uses.
b. to prevent or treat substance use disorders.
c. to reduce fatigue associated with depression.
d. in stabilizing the moods of the affected patient.

CORRECT ANSWERS:

1. **Dialectical behavior therapy (DBT) is a method of therapeutic intervention that helps a patient**

c. accept negative thoughts as they are.

"*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.*"

2. **A patient who is guided during therapy to understand that the patient is not defined by his or her thoughts is involved in**

b. cognitive-behavioral therapy (CBT).

"*Cognitive-behavioral therapy is a method that teaches a patient to recognize how thoughts and emotions affect a person's 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.*"

3. **Which of the following statements is true about prescribing antidepressants for patients with bipolar disorder?**

b. Antidepressant medications are NOT the first line of treatment for patients with bipolar disorder.

"*Antidepressant medications are not the first line of treatment for patients with bipolar disorder…. 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.*"

4. **_____ is an opioid antagonist drug that has been approved by the FDA for the treatment of substance use, including alcohol and opioid dependence.**

c. Naltrexone

"*Naltrexone is an opioid antagonist drug that has been approved by the FDA for the treatment of substance use, including alcohol and opioid use.*"

5. The most effective approach for treating substance use disorders that occur with a bipolar disorder is to treat

d. both conditions at the same time.

"*Historically, bipolar disorder and substance use disorder in a patient were treated separately at different times and in different facilities…. Experts now maintain 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 both situations.*"

6. A patient who is manic exhibits erratic behavior that causes the patient

a. to be revved up in energy and activity

"*Manic Phase: The manic phase is characterized by erratic behavior that causes a person to be revved up in energy and activity.*"

7. One of the key factors that complicates treating substance use disorders that occur with a bipolar disorder is that

a. symptoms of each disorder may overlap.

"*Treatment of co-occurring bipolar disorder and a substance use disorder can be difficult, as many of the symptoms associated with each condition may overlap.*"

8. Cognitive-behavioral therapy is a method that teaches a patient to

c. recognize how thoughts and emotions affect a person's behavior.

"*Cognitive-behavioral therapy is a method that teaches a patient to recognize how thoughts and emotions affect a person's behavior.*"

9. True or False: A cognitive-behavioral therapy (CBT) therapist may help a patient understand that thoughts are simply thoughts and they do not have to direct a person's behavior.

a. True

"*Therapists often work with patients to help them recognize that thoughts are simply thoughts and they do not have to control a person's behavior.*"

10. Dialectical behavior therapy (DBT) was originally developed to treat patients with

d. borderline personality disorder.

"*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. Dialectical behavior therapy has also been used successfully for treatment of a substance use disorder.*"

11. One aspect of integrated group therapy (IGT) is the use of _____, in which the patient with bipolar disorder will consider how his or her moods affect behavior.

b. cognitive-behavioral therapy (CBT)

"*One aspect of IGT is the use of cognitive-behavioral therapy, in which the patient with bipolar disorder will consider how his or her moods affect behavior. The patient may then develop methods for managing emotions during mood fluctuations so that the patient does not turn to substance use.*"

12. One of the most effective measures to manage bipolar and substance use disorders is to use medications to manage the bipolar disorder and _____, and cognitive-behavioral therapy (CBT) to address the co-occurring substance disorder.

a. acute withdrawal symptoms

"*Studies have shown that management of medication for bipolar disorder symptoms, combined with cognitive-behavioral therapy for management of co-occurring substance use, is one of the most effective measures to manage both disorders.*"

13. Standard antipsychotic medications are helpful in treating episodes of mania, particularly when

c. psychosis is present.

"*Standard antipsychotic medications are helpful in treating episodes of mania, particularly when psychosis is present.*"

14. True or False: Anticonvulsant drugs should not be used in bipolar patients who are experiencing rapid cycling.

b. False

"*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.*"

15. In a patient who has co-occurring bipolar disorder and substance use disorder, lithium can be beneficial

d. in stabilizing the moods of the affected patient.

"*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…. 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...*"

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