Chemical dependency in Bipolar Disorder

Thanks to Dr. Henson

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Q:

A patient with an alcohol problem is ambivalent about starting Acamprosate. The psychiatrist explores the patient’s thought about the advantages and disadvantages of taking and not taking the medication, attempting to tip the patient’s decisional balance in favor of taking the medication. Which of the following techniques is the physician using?

A) cognitive reframing
B) Contingency Management
C) Motivational enhancement
D) Pessimistic anticipation
E) Rational emotion
Q:
- A 15-year-old girl is brought in for an emergency evaluation because she has been out all night and refuses to tell her parents where she has been. The parents report that for several months the girl has been irritable and oppositional with severe mood swing. She has been leaving home and school without permission. The girl admits that she has been somewhat moody but insists that her parents are making a big deal about nothing. A preliminary diagnosis of bipolar disorder is made. Which of the following is the most common co-morbid condition with bipolar disorder?
  - A) Conduct disorder
  - B) Generalized Anxiety disorder
  - C) Oppositional Defiant Disorder
  - D) Posttraumatic Stress Disorder
  - E) Substance Use Disorder

Introduction
- In Bipolar Disorder:
  - Substance abuse is the rule rather than the exception
  - 60% of patients with BPD have a co-occurring lifetime substance use disorder (SUD)
  - Bipolar D/O Type I has the highest rate of co-morbid substance use among psychiatric disorders

Comorbid Bipolar Disorder and SUD
- Alcohol is the most common of substance abuse (46%)
- Followed by Marijuana (30% - 50%), Amphetamines, cocaine( 20% - 35%)
- sedatives and opioids are less frequently abused
- Worse prognosis
- Poorer response to Lithium
- Slower stabilization in hospital
- Suicide attempts more frequent
- Higher risk for relapse to substance abuse than with SUD alone
Co-morbid BPD and SUD continue
- Increased risk for e.g., Financial problems, Family problems, homelessness, violence, incarceration
- More Tx noncompliance & More Hospitalization

Problems making a diagnosis in dual disorders
- Substance abuse?
- Self-medication?
- Difficulty to differentiate substance-induced syndromes from other psychiatric disorders
- Often incomplete and/or inaccurate information

Substance abuse states that can mimic other psychiatric disorders
- Depression can be caused by the use of depressants (ETOH, Sedative)
- Mania can be caused by stimulants
- Psychosis can be caused by Marijuana, Amphetamines, cocaine and hallucinogens

Substance abuse states that can mimic other psychiatric disorders Continue:
- Early recovery $\rightarrow$ Sx of Withdrawal such as depression
- Mood swings $\leq 1$ year during recovery
- Impulsivity common feature of substance-use conditions are also symptoms of other disorders (ADD, Mania, personality disorder)
Psychiatric disease caused by substance abuse
- Unclear whether this occurs
- More likely expedites illnesses

Reasons to differentiate
- Dual diagnosis may need additional services
- More severe pathology
- May have reduced resources and/or support
- Combined with alcohol reduces efficacy and compliance
- Alcohol may make prognosis worse

Making the diagnosis
- Chronologic history
- Are psychiatric symptoms present during periods of abstinence
- Where there mood symptoms before the onset of substance abuse

Self-medication Hypothesis
- Reduce anxiety
- Blunt or control affect
- Sleep
- Pain
- Other somatic symptoms
- Attention
- Relieve withdrawal
Associations between specific substance and conditions

- BPD More common in those with cocaine dependence than alcohol dependence
- Depression more often associated with alcohol and opioid use
- of Mood and Anxiety Disorders, Mania associated with highest probability of drug dependence
- Lifetime occurrence of Bipolar Disorder in drug abuser is 3%-11% (excluding ETOH)

Risk Factors for developing drug abuse in Bipolar Patients

- Males
- Lower education
- Social supports
- Axis I Disorders
- Earlier onset of mood symptoms
- More mania than depression
- Rapid cycling or mixed state
Treatment Compliance in SUDs

Associated with better compliance
- Employment
- Older Age
- Education
- + Social Supports

Treatment Compliance in SUDs (cont’)

Associated with poor compliance
- Co-morbidity
- Severity of psychiatric symptoms
- Cognitive impairment
- Poor support systems

Disulfiram (eg, Antabuse)
- FDA approved for alcoholism
- Inhibits liver enzyme function
- Causes accumulation of toxic precursor
- Flushing, nausea, and vomiting if combined with alcohol
- Decreases frequency of drinking
- Not associated with long-term improvement
- Patient requires liver function tests
- Increased risk for psychosis
Disulfiram (cont’)
- More effective with impulsive drinkers or in high risk situations
- Use in addition with psychological treatment
- Can be used with alcohol by a small percentage without ill effects
- Take in the presence of a witness

Naltrexone
- FDA approved for alcoholism
- Lower craving, lower alcohol consumption, and decreased reward
- Monthly injection
- Disadvantages - blocks opioid receptors
- Early trials v. Large multicenter trial

Naltrexone
- Trials in population with Bipolar Disorder and Alcoholism
- Fewer studies
- Medication well tolerated
- Might indirectly improve mood symptoms
- Improved self-esteem and compliance with medication regimens
- Removing effects of alcohol consumption
Naltrexone and Disulfiram combination
- Study of each agent individually
- Each agent with placebo
- Combination of Naltrexone and Disulfiram
- Double placebo
- Improvement found in all groups

Acamprosate
- FDA approved for use in treating alcoholism
- 7 European trials - abstinence increased if with psychosocial interventions
- United States trials showed most effective in Highly motivated cases
Valproate
- Small trial
- Significantly lower number of drinking days
- Improved affect
- Decrease in GGT

Topiramate
- In theory it could help control compulsivity but no data available

Carbamazepine
- Some evidence of efficacy with Bipolar Disorder and co-morbid cocaine abuse

Lithium
- Little or no data available
Psychological Treatment

- Outcome better when treatment of Bipolar Disorder and substance use disorder are integrated
- Self-help groups
- Social stability
- Adherence to treatment

Cognitive Behavioral Therapy (CBT)

- Medical management plus CBT increased number of patients who completed treatment compared with groups receiving medical management alone
- Improvement in mood seen
- Treatment well liked by patients

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Motivational enhancement therapy is a form of psychotherapy that has been shown to be effective in the treatment of substance use disorder. It uses directive, empathic, patient-centered techniques to address ambivalence and denial.


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Substance use or abuse is an important diagnosis to consider in adolescents who present with symptoms consistent with bipolar disorder, both as a possible cause of the symptoms and as an important potential co-existing problem. This diagnosis has significant implications for treatment planning.

- Sadock BJ, Sadock VA (eds); Kaplan and Sadock’s Comprehensive Textbook of Psychiatry, 8th ed. Philadelphia, Lippincott & Williams & Wilkins, 2005, P 1577
Conclusions

- SUDs and Bipolar Disorder highly associated and have increased risks for poor outcomes
- Essential to integrate treatment for both
- Addiction pharmacotherapies and CBT shown to be beneficial
- Additional research needed
- Treatment compliance essential

Questions and Comments?

Thank you for your time