With prevalence rates as high as 50%-70%, substance abuse is highly prevalent in patients diagnosed with bipolar disorder. [1,2] As such, bipolar disorder and substance use disorders are often considered to be comorbid with the primary or leading diagnosis, on the basis of the patient's ability to recall whether emotional lability pre- or postdated their use of substances. Because bipolar disorder and substance-induced mood disorders can acutely present in an identical manner; differentiating between the 2 can be very difficult, if not impossible, when mood lability is manifested. [3-5]

As a medical expert for the Social Security Administration for over 25 years, I have had the privilege of reviewing thousands of medical records with the directive to determine whether substance abuse is a material factor leading to mood lability when another axis I diagnosis has also been made.

What I have learned over the years has firmly changed my thinking on the determination of the impact of substance use disorders on mood lability. I have come to appreciate that there is little to no value relying on a patient's recollection of when their emotional lability began, because memories falter and substance abusers invariably lie about their history of substance abuse. The diagnosis of a substance-induced mood disorder -- drugpolar disorder, for short -- should always be considered in patients with mood lability because it may be the primary, and possibly the only, true diagnosis.

That patients may claim that they used substances to ameliorate their labile moods does not alter the reality of the negative impact of substances on mood. Any abused substance that can affect mood (eg, alcohol, benzodiazepines, marijuana, opioids, and stimulants) can be expected to have a dramatically adverse effect on emotional stability with a commensurate negative impact on relationships and job opportunities.

What I have come to appreciate from reviewing a multitude of medical charts is that the only viable way to determine the contribution of substance abuse to mood lability is to observe the patient 6-12 months after substance abuse has stopped, when the negative impact of substances on emotional and functional well-being has mostly dissipated. In these cases, I have invariably seen that mood stabilizes dramatically and functionality with regard to jobs and relationships improves, at times even without the continuation of bipolar medications.

The lesson to be learned is that substance-induced mood disorders are incredibly common but mostly hidden and will turn out to be the correct or primary diagnosis in the majority of patients who carry a comorbid (dual) diagnosis.

In clinical practice, the rewards of stopping substance abuse should be repeatedly proffered to our patients. When advice regarding these rewards is heeded and taken seriously, it will pay huge dividends towards improvement in all patient domains.

After 28 years of clinical practice, I have finally graduated. The first mental health consideration (after ruling out physical disorders) on my differential for any mood-labile patient is -- you guessed it -- substance-induced mood disorder, or what I metaphorically call "drugpolar disorder."

References


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Cite this article: Is It Bipolar Disorder or Drugpolar Disorder?. Medscape. Nov 01, 2012.