BIPOLAR AFFECTIVE DISORDER TYPE I AND COCAINE USE: A CASE REPORT

Transtorno Afetivo Bipolar do tipo I e o uso de cocaína: um relato de caso

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ABSTRACT

This case report explores the complex interface between bipolar I disorder, and cocaine use disorder, presenting a multidimensional clinical challenge. It describes the evolution of a 56-year-old patient followed up in a mental health service, whose psychiatric condition is intertwined with problematic patterns of substance use. The study details the differential diagnostic process, which included the exclusion of conditions such as uncontrolled hyperthyroidism and major depressive disorder, as well as confirmation of the diagnosis using validated instruments. The therapeutic approach combined pharmacological strategies with lithium, valproic acid, and risperidone, associated with psychosocial interventions within the Psychosocial Care Centers. The importance of integration between drug treatment, participation in therapeutic groups, and strengthening the social support network is highlighted. The case demonstrates how the articulation between mental health and substance use care can promote better clinical outcomes, even in complex situations. The analysis highlights the need for integrated care models that consider both the neurobiological and psychosocial aspects involved in these dual conditions. Finally, the report reinforces the importance of public policies that guarantee access to specialized treatment for patients with psychiatric and substance use comorbidities, pointing to ways to improve clinical practice in these challenging cases.

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Keywords: Bipolar disorder type I. Cocaine use disorder. Psychiatric comorbidity. Integrated approach. Psychosocial care centers.

RESUMO
Este relato de caso explora a complexa interface entre o transtorno afetivo bipolar do tipo I e o transtorno por uso de cocaína, apresentando um desafio clínico multidimensional. Descreve a evolução de um paciente de 56 anos acompanhado em serviço de saúde mental, cuja condição psiquiátrica se entrelaça com padrões problemáticos de uso de substâncias. O trabalho detalha o processo diagnóstico diferencial que incluiu a exclusão de condições como hipertireoidismo descompensado e transtorno depressivo maior, além da confirmação do diagnóstico através de instrumentos validados. A abordagem terapêutica combinou estratégias farmacológicas com lítio, ácido valpróico e risperidona, associadas a intervenções psicossociais no âmbito dos Centros de Atenção Psicossocial. Destaca-se a importância da integração entre tratamento medicamentoso, participação em grupos terapêuticos e fortalecimento da rede de apoio social. O caso demonstra como a articulação entre saúde mental e atenção ao uso de substâncias pode promover melhores desfechos clínicos, mesmo em situações complexas. A análise evidencia a necessidade de modelos de cuidado integrados que considerem tanto os aspectos neurobiológicos quanto os psicossociais envolvidos nestes quadros duplos. Por fim, o relato reforça a importância de políticas públicas que garantam acesso a tratamentos especializados para pacientes com comorbidades psiquiátricas e por uso de substâncias, apontando caminhos para a melhoria da prática clínica nestes casos desafiadores.

Palavras-chave: Abordagem integrada. Centros de atenção psicossocial. Comorbidade psiquiátrica. Transtorno bipolar tipo I. Transtorno por uso de cocaína.

1 INTRODUCTION

Bipolar affective disorder is a complex and heterogeneous psychiatric condition marked by extreme mood fluctuations, including episodes of mania, hypomania, and depression. It affects a significant proportion of the population and ranks among the leading causes of disability worldwide. Although recent advances in biological psychiatry have provided valuable insights into its underlying mechanisms, the disorder's pathophysiology remains incompletely understood (Kapczinski, 2004).

Bipolar II disorder is characterized by recurrent mood episodes involving at least one major depressive episode and one hypomanic episode. In contrast, the diagnosis of bipolar I disorder requires the presence of at least one manic episode, which may or not be preceded or followed by depressive episodes (Nascimento, 2014). Manic and hypomanic episodes are typically characterized by elevated mood, increased energy, and heightened activity, whereas depressive episodes involve sadness, hopelessness, and low energy (Sanches, 2004). Accurate diagnosis is often challenging due to symptoms overlapping with other psychiatric conditions, such as major depressive disorder or personality disorders (Sanches, 2004).

Substance use is frequently observed among individuals with bipolar disorder. Commonly used substances include cannabis, nicotine, alcohol, and particularly cocaine. Cocaine use is especially concerning, as it can act as both a trigger and an exacerbation factor in bipolar disorder, with a higher prevalence of type I presentations among cocaine users compared to alcohol users. The scarcity of studies on concurrent cocaine and polysubstance use further complicates diagnoses and impedes a clear understanding of the relationship between substance dependence and affective disorders (Mitchell, 2007).

Additionally, cultural factors significantly influence the presentation, interpretation, and management of bipolar disorder (BD). Understanding these transcultural dimensions is essential for delivering effective and personalized mental health care that respects patients' beliefs, values, and cultural practices (Menezes, 2011).

Management of bipolar disorder typically involves a multidisciplinary approach that includes mood stabilizers, psychotherapy, and self-care strategies. Psychoeducation, aimed at increasing illness awareness and developing coping skills, has proven to be a key component in relapse prevention and long-term treatment success (Menezes, 2011).

2 CASE DESCRIPTION

2.1 Identification

E.L.D.M, 56 years old, male, black, divorced, vehicle security guard, born in Jaguaritira, district of Malacacheta - MG. Currently residing in Ribeirão Preto - SP for 38 years. Practicing Evangelical Christian. Health insurance: Sistema Único de Saúde (SUS) - Brazilian Unified Health System.

2.2 Main Complaint

"Bipolar disorder since 2018"

2.3 History of Present Illness

The patient presents at the Psychosocial Care Center (CAPS) for follow-up of bipolar affective disorder. He reports that in 1992 he had his first contact with drugs: he began to use alcohol recreationally. He consumed around 3 bottles of 600 ml of beer on weekends. Later, in 1995, he started using cocaine. He began with 1 "pino" (a small container typically used for cocaine) per day, a pattern that lasted for several years. Subsequently, there was a progression to 4 "pinos" per day. Euphoria, increased energy, and libido were reported as immediate effects of using this drug. However, after these effects wore off, the patient felt sad and regretful.

In 2013, he expressed the desire to stop using drugs and was admitted to a rehabilitation clinic. He managed to stay off cocaine for 8 months but resumed its use. In 2019, there was another attempt to cease drug use, this time lasting for 1 year and 8 months. In May 2022, he resorted to admission to the aforementioned clinic again, staying away from drugs for 6 months. His last "pino" was 7 months ago, in April 2023. Since then, there have been no new relapses, and alcohol consumption, considered a trigger by the patient, has also been discontinued during the same period.

In July 2018, there was a notable change in his behavior. He began to believe that he was an extremely wealthy and well-traveled person, even thinking that he had visited cities like Dubai and New York, among others around the world. Additionally, his sleep pattern underwent significant changes, with him sleeping little and starting his sleep around 10:00 p.m., waking up at 2:00 a.m., feeling completely refreshed.

During this period, he also developed peculiar habits, such as collecting bottles from the street and spending long hours changing their caps.

Furthermore, he would donate money to every beggar he encountered and incessantly call the Mobile Emergency Care Service (SAMU) to arrange care for these homeless individuals.

His energy level increased considerably compared to his usual state. His speech became rapid, and his thoughts seemed accelerated. He started to engage more easily with women and showed to be more generous with people. He mentioned that at the time his grandson was hospitalized, and he wanted to visit him several times a day. He denied hearing voices or seeing things that didn't exist.

These symptoms persisted daily for about 4 months until his family decided to seek help at a private hospital in the countryside of São Paulo state in October 2022. During the assessment, laboratory tests were conducted (details were not described in the medical record), and he was prescribed the following medications: valproic acid 1500 mg/day, risperidone 1 mg/day, and clonazepam 2 mg/day.

In 2019, he was referred for follow-up at the CAPS, already in remission from manic symptoms. In 2020, there were changes in his treatment, including the use of: valproic acid 500 mg (0-0-1), clonazepam 2 mg (0-0-1), and nortriptyline 25 mg (0-0-2).

In September 2021, he discontinued the medication treatment on his own, believing he was well and no longer needed the medication. This coincided with an increase in his energy, decreased need for sleep, and a relapse in cocaine use. As a result, he sought medical attention in November 2021, when treatment with valproic acid 500 mg (0-0-1) and clonazepam 2 mg (0-0-1) was resumed.

About a month later, the patient began to manifest symptoms such as sadness, anhedonia, insomnia, reduced energy, and low self-esteem. In February 2022, these complaints were discussed during a medical consultation, and the decision was made to optimize treatment by adding lithium 300 mg (1-0-1).

With the persistence of depressive symptoms until October 2022, there was a new adjustment in medications: discontinuation of nortriptyline, initiation of sertraline 50 mg (1-0-0), optimization of valproic acid with the addition of another 250 mg tablet, totaling 750 mg/day, and maintenance of lithium and

clonazepam. In November 2023, risperidone 2 mg (0-0-1/2) was prescribed due to complaints of insomnia.

In today's consultation, the patient mentioned the persistence of anhedonia and sadness. Although he noticed some improvement in insomnia. He denied thoughts of death and suicidal ideation.

As part of the ongoing psychiatric and psychosocial management, the patient has been engaged in a structured care program through the Psychosocial Care Center (CAPS), with regular follow-ups since 2019. In addition to pharmacological treatment, his care plan includes multidisciplinary interventions aimed at relapse prevention and mood stabilization.

Notably, the patient has participated consistently in therapeutic groups offered at CAPS, specifically designed for individuals with mood disorders. These groups have addressed psychoeducation on bipolar disorder, emotional regulation, routine structuring, medication adherence, and social reintegration strategies. Through these sessions, he has demonstrated improved insight into the cyclical nature of his illness and developed better strategies to recognize early warning signs of relapse.

Furthermore, due to his history of substance use, he is also followed by the CAPS AD (Alcohol and Drugs unit), where he benefits from an integrated model of care. This includes individual psychological counseling focused on relapse prevention and harm reduction, social support to manage vulnerabilities related to his socioeconomic context, and occupational therapy interventions aimed at restoring his functional autonomy and motivation for everyday activities.

The involvement of a multidisciplinary team—comprising psychiatry, psychology, nursing, social work, and occupational therapy—has been essential in offering comprehensive care. This approach has promoted the patient’s continued abstinence from cocaine and alcohol since April 2023 and contributed to partial improvements in mood symptoms and sleep quality, as observed during this consultation. The patient also participates in a support group for depression, facilitated by the CAPS, and engages in religious activities, both of which serve as important protective factors.

In summary, the clinical approach has not been limited to pharmacotherapy but has incorporated community-based and psychosocial

interventions tailored to his dual diagnosis of bipolar I disorder and stimulant use disorder. This integrative strategy reflects the broader objective of psychiatric rehabilitation and sustained functional recovery.

2.4 Personal Pathological History

There is no history of surgeries, accidents, or allergies. The patient underwent two voluntary admissions to a rehabilitation clinic, the first in 2013 and the second in May 2022. Regarding previous medical conditions, he has a history of hyperthyroidism and systemic arterial hypertension, both of which are controlled.

2.5 Medications Currently in Use:

- Carbonate of lithium 300 mg 1-0-1
- Valproic acid 750 mg 1-0-0
- Risperidone 2 mg 0-0-1/2
- Clonazepam 2 mg 0-0-1
- Sertraline 50 mg 1-0-0
- Losartan 50 mg 1-1-0
- Methimazole 5 mg 1-0-0

2.6 Lifestyle Habits

The patient maintains a regular sleep routine, going to bed around 10:00 PM and waking up at 6:00 AM, with no reported nightmares or other sleep disturbances. His diet is balanced and consists of regular, portioned meals without specific dietary restrictions.

Regarding substance use, the patient acknowledges previous alcohol and cocaine use, as mentioned earlier. He denies tobacco, marijuana, and other drug use. There is no recollection of stressful life events.

The patient reports that the symptoms of bipolar affective disorder adversely impact his life, resulting in a lack of enthusiasm to interact with others and dedicate himself to work. He emphasizes the presence of a support network in which he trusts, mainly composed of his children and his sister, but not limited to them. Additionally, the patient actively participates in church celebrations and the depression support group at the CAPS.

2.7 Prenatal / Birth History

The patient was born at term through an out-of-hospital vaginal delivery. There is no history of neonatal hospitalization or resuscitation procedures. However, there is no available information regarding the APGAR score, birth weight, or other data related to his birth.

2.8 Childhood Development History

The patient reports a robust health history, denying any childhood illnesses, dietary restrictions, delays in motor and language development, or any food deprivations or selectivity. Regarding temperament, he claims to have maintained a consistently calm and patient demeanor throughout his life. His social interaction ability has always been notable, demonstrating appropriate and healthy relationships with others.

2.9 Adolescent History

Throughout adolescence, the patient maintained his characteristic of being calm, cultivating a strong bond with his family, and establishing positive relationships with classmates. He highlights that during this period, he excelled academically, being recognized as the top student in his class, especially in mathematics. However, despite his academic talent, his educational journey was interrupted, reaching only the fourth year of elementary school.

It is important to note that the patient denies experiences of bullying, relationship instability, depressive episodes, or any indication of social isolation.

2.10 Adult History

2.10.1 Work

Initiated his professional journey at the age of seven, performing weeding and grass-cutting tasks in rural areas. At the age of 14, he transitioned to the position of storekeeper in a vehicle company, and at 18, he opted for professional autonomy by becoming self-employed. Currently, he works as a vehicle security guard.

The patient reports that he has always found satisfaction in his professional activities, highlighting that throughout his career, he has not

encountered difficulties related to competence or in his relationships with colleagues.

2.10.2 Marital and Family Life

The patient experienced two marriages throughout his conjugal life. The first relationship lasted for 29 years but came to an end due to disagreements between the couple. The second marriage was shorter, lasting less than 1 year, as his fiancée chose to return to her homeland.

Despite these marital experiences, the patient denies facing any significant difficulties in his relationships or sexual experiences. As a father, the patient has three children, all from the first relationship. Unfortunately, one of them passed away at the age of 1 year and 6 months due to a domestic accident. The other two children, a 27-year-old daughter and a 24-year-old son, are alive, and the patient emphasizes having a good relationship with both.

2.10.3 Socioeconomic Situation

Currently, the patient resides in a rented house, sharing the space with his father and two of his siblings. He contributes financially with resources from the Bolsa Família program. However, the main source of family support is his father's retirement pension and his siblings' salaries.

2.11 Family History

The patient is part of a large family, composed of eight siblings, all in good health. His father, aged 85, has controlled hypertension. Unfortunately, his mother passed away at the age of 74 due to an acute myocardial infarction and suffered from major depressive disorder. Both patient’s children are in good health.

The patient denies any history of suicide in the family. However, he mentions that one of his brothers has a history of law violation.

2.12 Pré-Morbid Personality

The patient demonstrates heightened attention to detail, reflected in concerns with order, cleanliness, and punctuality. His habitual mood tends toward the hypotymic. Although capable of expressing feelings, he does so cautiously, showing concern about not burdening others with his emotions.

2.13 Physical Examination

Patient with an active posture. Good overall condition, well-nourished, with unremarkable facies. Hydrated, normochromic, acyanotic, and non-jaundiced. Vital signs: SatO2: 97%, RR: 14 breaths per minute, HR: 78 beats per minute, Temp: 36.2°C, BP: 130/80 mmHg.

Thyroid palpable and normal-sized, with a fibroelastic texture, non-tender, mobile with swallowing, and no palpable nodules. Cardiovascular system with two normal-rhythm and normophonetic heart sounds, without murmurs. Symmetrical chest, absence of bulges, depressions, or elementary lesions. Presence of vesicular breath sounds, no adventitious sounds. Clear lung sounds, with present thoracic vocal fremitus. Abdominal physical examination was not performed due to the absence of an examination table in the unit.

2.14 Psychiatric Examination

The patient was seen in the office of the CAPS by a medical intern. The environment was quiet, well-lit, and air-conditioned. The patient had good hygiene and was appropriately dressed for the weather. His chronological age was consistent with his apparent age, and there were no alterations in psychomotor activity. The patient's thinking was organized and logical, with predominantly optimistic content. There was an absence of thoughts of death or suicidal ideation. Speech was organized and coherent with reality. The flow, speed, and tone were appropriate. The patient's mood was hypotymic, and affect was congruent and within normal range. The patient was alert, oriented to person, place, and time, and there were no alterations in sensory perception. He exhibited notable intelligence with preserved memory. There was a presence of critical judgment of reality and good insight.

2.15 Diagnostic Hypotheses

- Bipolar I Disorder
- Substance Use Disorder (Stimulant)

3 DISCUSSION

The present case of E.L.D.M. paradigmatically illustrates the diagnostic and therapeutic challenges at the interface between bipolar affective disorder (BD) and psychoactive substance use, particularly cocaine. The complexity of the condition is evident in the difficulty of establishing a linear causal relationship between mood episodes and substance use patterns. It is known that illicit drug users are 20.5 times more likely to develop BD (SADOCK, 2017). During follow-up, the patient revealed an ambivalent perception of this relationship: “When I use, it seems like I control everything, but then chaos ensues,” demonstrating the cyclical and self-perpetuating nature of this dual diagnosis.

The differential diagnosis with general medical conditions, such as hyperthyroidism, is particularly relevant in this case, especially considering the episode in July 2018, when the patient presented mixed symptoms during treatment with Methimazole. As noted, substances such as cocaine, cannabis, alcohol, and tobacco are often associated with TAB, but concomitant endocrine changes add a layer of complexity (SILVEIRA AND WEBER, 2020). The patient himself reported: “At the time, I thought my energy came from happiness, I didn't imagine it could be the medicine or the thyroid,” illustrating how somatic aspects can be misinterpreted as purely psychological manifestations.

Diagnostic confirmation through the Mood Disorder Questionnaire (MDQ), as attached, proved to be a milestone in the patient's understanding of the case, who commented: “I finally understood that my crises followed a pattern.” This instrument, combined with careful clinical evaluation, made it possible to differentiate TAB from major depressive disorder, as recommended in the specialized literature. The period of September 2021, marked by voluntary medication interruption followed by relapse into cocaine use, was described by the patient as “a cycle that he could not break on his own,” reinforcing the findings on recurring patterns in this clinical population (LALLI et al., 2021).

The pharmacological approach employed, based on lithium carbonate, valproic acid, and risperidone, proved to be adequate according to established parameters (SADOCK, 2017). Lithium, with its mood-stabilizing effects proven in about 80% of cases of type I BPD, associated with valproic acid—which potentiates GABAergic activity as described by the same author—and

risperidone, with its antagonistic action on serotonergic and dopaminergic receptors, formed the basis of the treatment. The patient demonstrated progressive awareness of the benefits of this approach: “I realized that the medications gave me a balance that cocaine promised but never delivered,” reporting significant improvement during periods of therapeutic adherence.

The psychosocial dimension of treatment proved equally crucial. Participation in depression support groups and involvement in religious activities were described by the patient as “points of support when the urge to use came,” corroborating the importance of multimodal interventions (SADOCK, 2017). Cognitive-behavioral therapy, not yet systematically implemented in this case, could address dysfunctional thinking patterns as the patient himself pointed out: “I feel like I fail when I feel like using,” demonstrating the need to work on cognitive distortions associated with substance use.

Longitudinal follow-up at the Psychosocial Care Center (CAPS) allowed for a broader understanding of the clinical history, incorporating family relationships and the support network as fundamental therapeutic elements. As the patient concluded in one of his last consultations: “I learned that my recovery is not just about stopping using, but about understanding what led me to use,” a summary that reflects the contemporary conceptual evolution in the treatment of dual disorders.

This case reinforces the need for integrated approaches that consider both the neurobiology of mental disorders and the psychosocial dimensions involved, maintaining rigorous monitoring of clinical and laboratory parameters (such as serum lithium levels and thyroid function), without losing sight of the patient's subjective experience and their social determinants of health. Continuing education about the disease and its treatments, combined with the strengthening of support networks, is central to promoting not only symptomatic stability but also the reconstruction of the life project, as demonstrated in the evolution of E.L.D.M.

4 CONCLUSION

The case of E.L.D.M. illustrates the complexity of the interaction between cocaine use and episodes of mania and depression associated with bipolar I disorder. This scenario highlights the urgent need for a comprehensive

assessment that goes beyond psychiatric symptoms, recognizing the various facets that permeate a psychiatric diagnosis. In this context, effective psychiatric treatment must be holistic, integrating strategies that leverage support networks, providing health education, promoting the exchange of experiences through therapeutic groups, and incorporate a multidisciplinary approach.

It is worth noting that, in addition to therapeutic aspects, it is imperative to consider differential diagnoses. In the case in question, the possibility of hyperthyroidism decompensation and major depressive disorder was considered. However, a thorough analysis, combined with the application of the mood questionnaire, reinforced the compatibility with BPD, providing a solid basis for guiding clinical intervention and promoting the patient's well-being. This diagnostic confirmation was fundamental in guiding pharmacological management, which combined lithium carbonate, valproic acid, and risperidone with positive results in mood stabilization.

In addition, the patient's experience showed how a purely pharmacological approach would be insufficient without the integration of psychosocial strategies. In this sense, participation in therapeutic groups at CAPS, family support, and involvement in religious activities proved to be as crucial as pharmacotherapy, acting as key elements in maintaining abstinence and functional recovery. It is worth noting that cognitive-behavioral therapy, which has not yet been implemented systematically, could represent an additional advance in treatment, addressing cognitive distortions related to substance use.

Finally, this case reinforces the importance of public policies that guarantee access to integrated treatments for patients with severe mental disorders and substance use comorbidities. E.L.D.M. 's experience demonstrates that, when combined with a consistent support network and ongoing psychosocial interventions, pharmacological resources can promote not only symptomatic stability but also the reconstruction of a meaningful life project. Thus, this report serves as a call for mental health services to increasingly adopt biopsychosocial approaches capable of addressing the complexity inherent in cases such as this.

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