



Research report

The impact of mood symptomatology on pattern of substance use among homeless



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ABSTRACT

Background: Homeless individuals are an extremely vulnerable and underserved population characterized by overlapping problems of mental illness and substance use. Given the fact that mood disorders are frequently associated with substance use disorders, we wanted to further highlight the role of excitement in substance abuse. Patterns of substance abuse among homeless suffering from unipolar and bipolar depression were compared. The “self-medication hypothesis” which would predict no-differences in substance preference by unipolar (UP) and bipolar (BP) depressed homeless was tested.

Methods: Homeless individuals from the Vancouver At Home/Chez Soi study were selected for lifetime UP and lifetime BP depression and patterns of substances abused in the previous 12 months were identified with the Mini-International Neuropsychiatric Interview. Differences in substance use between BP-depressed homeless and UP-depressed homeless were tested using Chi-square and logistic regression techniques.

Results: No significant differences were observed between UP and BP homeless demographics. The bipolar depressed homeless (BDH) group displayed a higher percentage of Central Nervous System (CNS) Stimulants (χ^2 8.66, $p=0.004$) and Opiates (χ^2 6.41, $p=0.013$) as compared to the unipolar depressed homeless (UDH) group. CSN Stimulant was the only predictor within the BDH Group (χ^2 8.74 df 1 $p < 0.003$).

Limitations: Data collected are self-reported and no urinalyses were performed.

Conclusions: The results support the hypothesis that beyond the self-medication hypothesis, bipolarity is strictly correlated to substance use; this correlation is also verified in a homeless population.

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1. Introduction

Homeless individuals are an extremely vulnerable and an underserved population (Krausz et al., 2013) and pose a challenge to individuals, communities, and public systems of care (Fichter and Quadflieg, 2001). Homeless populations are characterized by a high prevalence of substance use disorders (SUD) and serious mental illness (Fazel et al., 2008; Krausz et al., 2013; Palepu et al., 2013; Patterson et al., 2013). Between 29% and 75% of homeless use alcohol and/or

illicit drugs (Edens et al., 2011; Schutz et al., 2013; Velasquez et al., 2000; Vila-Rodriguez et al., 2013), while alcohol in particular has been found to be used by 35–51% of homeless samples tested (Haugland et al., 1997; Kushel et al., 2001; O’Toole T et al., 2004).

With drug use increasing it can be challenged that illicit drugs may eclipse or outcompete alcohol as the substance of choice in this population (North et al., 2004; O’Toole T et al., 2004). Substances such as cocaine have become extremely popular and found to be used by 29–49% of homeless (Appel et al., 2001; Haugland et al., 1997; Lambert and Caces, 1995; Lee et al., 2005) with a SUD prevalence rate of about 49–53% (Haugland et al., 1997; O’Toole T et al., 2004). Crack cocaine in particular has experienced a remarkable rise in use among homeless populations over the last two decades (Fischer and Breakey, 1991; North et al., 2004), attributed at least in part to greater availability and affordability of the drug (North et al., 2010).

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A number of studies have found between one quarter and one third of homeless persons have a serious mental illness such as schizophrenia, bipolar disorder, or major depressive disorder (Fischer and Breakey, 1991; Folsom and Jeste, 2002; Sullivan et al., 2000). Of particular interest is the huge variation in prevalence for major psychiatric diagnoses observed across studies. For example, psychosis ranges from 2% to 31%, depression from 4% to 41%, and personality disorder from 3% to 71% (Fazel et al., 2008). Mental disorder estimates from homeless studies in Western countries have found the prevalence rate of having at least one current mental disorder to be approximately 50–70% (Fazel et al., 2008; Fischer and Breakey, 1991; Koegel et al., 1988; North et al., 2004; Vazquez et al., 1997), while in North America, in particular, can be as high as 95%. This large variation is likely driven by a high prevalence of co-morbid substance dependence (82.6%) (Krausz et al., 2013).

1.1. Bipolar disorder in homeless populations

Bipolar depression is of particular interest in homeless populations because individuals with bipolar disorder have higher rates of homelessness, compared to those with unipolar depression (Folsom et al., 2005). Similarly, patients who had a history of homelessness have increased odds of being assessed for bipolar symptoms (Kilbourne et al., 2010). In recent studies, bipolar disorder, particularly lifetime hypomanic symptoms were found to be present in 40–44% of a Canadian homeless population (Krausz et al., 2013; Schutz et al., 2013). Moreover, homeless individuals described as problem gamblers were 3.6 times more likely than non-problem homeless gamblers to meet diagnostic criteria for bipolar disorder (Nower et al., 2014). However, the extant literature provides circumstantial evidence at best on substance use and bipolar disorder in actual homeless populations.

In contrast, within non-homeless populations a great deal more is understood between the relationship of bipolar disorder and substance misuse. Foremost, they are commonly co-morbid (Merikangas et al., 2008) with the bipolar spectrum being associated with cocaine (Cocores et al., 1987; Maremmi et al., 2008; Nunes et al., 1989; Perugi et al., 2012; Post and Kalivas, 2013; Weiss and Mirin, 1986), cannabis (Arias et al., 2013; Ashton et al., 2005; Do and Mezuk, 2013; Maremmi et al., 2000b, 2004, 2006a), benzodiazepines (Brunette et al., 2003; Lin et al., 2011; Perugi et al., 2002), alcohol (Bernardt and Murray, 1986; Brousse et al., 2008; Chengappa et al., 2000; Dunner et al., 1979; Farren et al., 2013; Fletcher et al., 2013; Freed, 1969; Nery et al., 2010; Weiss and Mirin, 1989) and heroin (Maremmi, 2013; Maremmi et al., 2014a). Indeed, because bipolar spectrum disorders and addiction are so often comorbid, each operates as reciprocal risk factors and should be viewed from a unified perspective (Camacho and Akiskal, 2005; Maremmi et al., 2006b). Maremmi et al. (2002) and later Pani et al. (2010) suggested that the bipolar spectrum is the psychic substrate for the development of a substance-resorting attitude. For example, cyclothymic and irritable traits rather than mood elation and mania can lead to increase exposure of pro-manic stimulation in a self-regenerating circuit (Maremmi et al., 2009, 2006b). From this broader perspective, mood, anxiety and impulse-control dysregulation is thought to be at the very core of both the origins and clinical manifestations of addiction (Pani et al., 2010).

A popular explanatory construct is the “self-medication hypothesis” (SMH), as originally described by Khantzian (Khantzian, 1985). The SMH suggests that at the heart of addictive disorders is suffering, not the seeking of pleasure, reward, or self-destruction. There are two important aspects of the SMH: (1) Individuals use, abuse, and become dependent upon substances because they relieve states of distress; and (2) there is a considerable degree of psychopharmacologic specificity in an individual's preferred drug. Experimenting with different drugs, a person susceptible to addiction would discover that a particular drug relieves, ameliorates, or changes different painful affect (e.g. feeling) states and becomes a favoured drug (Khantzian, 1985).

The purpose of this paper is two-fold: first, to describe the pattern of substance use in a homeless population with mood disorders in the past 12 months. Second, to determine if different mood symptoms (unipolar vs. bipolar) are associated with different substances as suggested by the self-medication hypothesis (SMH).

2. Methods

2.1. Design of the study

This study is a cross sectional naturalistic study. The study utilizes data from the At Home/Chez Soi study which is a 4-year randomized control study, designed to test the effectiveness of Housing First for mentally ill homeless across five major cities in Canada (Goering et al., 2011). The present study included patients who participated in the City of Vancouver wing of the At Home/Chez Soi study. All participants are Canadian citizens, at least 19 years of age, who met criteria for homelessness or precarious housing and have a current mental disorder. Data were collected during face-to-face interviews in specific facilities. For details see Goering et al. (2011) and Somers et al. (2013).

2.2. Sample

The Vancouver sample of the At Home/Chez Soi study sample is comprised of 497 subjects. All subjects met criteria for homelessness or precarious housing and received a diagnosis of mental illness, according to Mini-International Neuropsychiatric Interview (MINI). For the present study, these patients were screened for 1) current or past depressive episodes, and 2) current or past manic or hypomanic episodes to a baseline evaluation to identify subjects affected by unipolar and bipolar depression. This yielded 319 homeless individuals: mean age was 39 ± 10 (range: 19–66). A total of 223 (69.9%) were males; 52 (16.3%) with aboriginal origin; 180 (56.4%) with less than 9 years of education; 302 (94.7%) living alone; 303 (95%) unemployed. Of the 319 subjects, 153 homeless had a history of bipolar depression (48%). Of these, 101 (66%) were males; mean age was 40 ± 10 (range: 20–66). A total of 166 homeless had a history of unipolar depression (52%). Of these 122 (73.5%) were males; mean age was 39 ± 11 (range: 19–65). These two groups were then compared for demographic and substance use variables.

2.3. Instruments

The following instruments were used:

2.3.1. Mini-International Neuropsychiatric Interview (MINI)

Lifetime and current mental and substance use disorders were estimated from the MINI International Neuropsychiatric Interview Plus, version 5.0.0 (Sheehan et al., 1998). The MINI Plus is a structured clinical interview based on the diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) (A.P.A., 1994) and the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10) (WHO, 1992). It was designed to assess Axis I substance use disorders and mental disorders as well as Axis II antisocial personality disorder. For the current study, we included information regarding the following diagnoses: drug dependence, alcohol dependence, depressive, manic, and hypomanic episodes, psychotic disorders, panic disorder, social anxiety disorder, posttraumatic stress disorder (PTSD), and obsessive-compulsive disorder (OCD). The time frames used to assess current mental disorders were 4 weeks for psychotic disorder, panic disorder, social anxiety disorder, PTSD, and OCD; 12 months for alcohol dependence and drug dependence; 2 weeks for depressive episodes; and “current” for manic and hypomanic episodes. The MINI Plus has been shown to be reliable

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