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Research report

Reasons for substance use in dual diagnosis bipolar disorder and substance use disorders: A qualitative study

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Abstract

Background: Few systematic studies have examined the reasons why patients with bipolar disorder and substance use disorders misuse alcohol and drugs of abuse. Such reasons may depend heavily on context so qualitative research methods that made no prior theoretical assumptions were employed. We explored the reasons patients give for misusing drugs and alcohol and how these relate to their illness course.
Method: Qualitative semi-structured interviews and thematic analysis with a purposive sample of 15 patients with bipolar disorder and a current or past history of drug or alcohol use disorders.
Results: Patients based their patterns of and reasons for substance use on previous personal experiences rather than other sources of information. Reasons for substance use were idiosyncratic, and were both mood related and unrelated. Contextual factors such as mood, drug and social often modified the patient's personal experience of substance use. Five thematic categories emerged: experimenting in the early illness; living with serious mental illness; enjoying the effects of substances; feeling normal; and managing stress.
Limitations: The prevalence of these underlying themes was not established and the results may not apply to populations with different cultural norms.
Conclusions: Patterns of substance use and reasons for use are idiosyncratic to the individual and evolve through personal experience. Motivating the patient to change their substance use requires an understanding of their previous personal experience of substance use both in relation to the different phases of their bipolar disorder and their wider personal needs.

Keywords: Bipolar disorder; Alcohol abuse; Alcohol dependence; Substance abuse; Substance dependence; Self-medication

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1. Introduction

The lifetime prevalence of alcohol abuse and drug abuse in people with bipolar disorder is known to be three to nine times that of the general population (Regier et al., 1990; Ten Have et al., 2002; Merikangas et al., 2007). Among patients hospitalised for mania or mixed affective episodes, nearly 60% had a lifetime diagnosis of substance use disorder (Cassidy et al., 2001). Negative outcomes have been reported in patients with bipolar disorder and comorbid substance use disorders including suicide (Isometsa, 2005), suicide attempts (Hawton et al., 2005; Simon et al., 2007), poor insight and denial of illness (Salloum and Thase, 2000), and treatment non-adherence (Keck et al., 1998). Therefore patients with dual diagnosis bipolar disorder and substance use disorders form an important group of patients to study from clinical and public health perspectives.

There have been no previous systematic qualitative analyses of substance use in bipolar disorder, and few systematic studies of any design concerning the reasons why patients with bipolar disorder abuse alcohol and illicit drugs. Reasons for substance use in bipolar disorder include the self-medication hypothesis, an attempt by patients to reduce the intensity of their symptoms through alcohol and street drugs (Strawkowski and DelBello, 2000; Weiss et al., 2004; Bizzarri et al., 2007a). Strakowski and DelBello (2000) also found some evidence to suggest that substance use may be a symptom or precipitant of bipolar disorder, and that bipolar disorder and substance use disorders may share common risk factors such as impulsivity (Swann et al., 2005), comorbidity with anxiety disorder (Mitchell et al., 2007; Goldstein and Levitt, 2008) or sensation seeking (Bizzarri et al., 2007b). Substance use can be a coping mechanism for managing the early symptoms or prodromes of manic and depressive episodes before the full episode of mania or depression appears (Lam and Wong, 1997; Lam and Wong, 2005).

A clinical approach to tackling the co-occurrence of bipolar disorder and substance use disorders involves motivational interviewing to modify the substance abuse and a formulation of how the reasons for substance use relate to the phase of illness and the person with bipolar disorder (Weiss et al., 2007). An understanding of the patient's perspective is key to therapeutic success because this information can be used both in the formulation of the patient's problems, and to communicate and motivate the patient to change their substance use behaviour. We explored how patients with dual diagnosis bipolar disorder and substance use disorders viewed the relationship between substance use and bipolar disorder in an inductive qualitative study that made no assumptions about the relationship between mood and substance use.

2. Method

2.1. Study sample

All patients included in the study were adults with a diagnosis of bipolar 1 disorder and current and/or past alcohol or drug abuse or dependence. Inclusion criteria were: 1. a SCID-DSM-IV diagnosis of bipolar disorder (First et al., 1997); 2. a SCID-DSM-IV diagnosis of substance use disorder (First et al., 1997); 3. 18 years of age or older; 4. willing to give written informed consent. Exclusion criteria were: 1. bipolar disorder secondary to an organic cause; 2. a current DSM-IV mood episode (mania, mixed affective episode, hypomania or major depression) (American Psychiatric Association, 1994). The study had ethics approval from a local research ethics committee and also local institutional research governance approval.

Purposive sampling was used to achieve maximum variance in terms of sociodemographic, clinical diversity and experience of substance use. We wished to explore the relationship of both phase of illness and type of substance use on the reasons given for substance use. Therefore we sampled for the following patterns of current or past alcohol and drug abuse or dependence: heavy regular alcohol dependence, binge drinking alcohol dependence, alcohol abuse and similar patterns of heavy regular and irregular use of opiates, cannabis, stimulant, hallucinogen and non-alcoholic sedative drugs. We also sampled to obtain a diverse clinical sample in relation to bipolar disorder: patients with fewer or more than five previous episodes; bipolar disorder with a history of psychosis; bipolar disorder with a history of rapid cycling; bipolar disorder with comorbid anxiety disorder; and bipolar disorder with comorbid personality disorder. The sample was also selected to provide diversity in terms of gender, age (18–30, 31–45, 46–65, over 65 years), marital status (married, single, divorced or separated, widowed), and social class (professional or managerial, skilled, semi-skilled, unskilled, unemployed). Patients were recruited from out-patients, community mental health teams or specialist drug and alcohol services serving two mental health trusts in north-west England.

2.2. Procedure

Semi-structured interviews were conducted (by CH) with each patient. A topic guide provided a flexible interview framework starting with an outline of the course the patient's illness and their experience of substance use.