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Research report

Clinical features, response to treatment and functional outcome of bipolar disorder patients with and without co-occurring substance use disorder: 1-year follow-up

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Abstract

Introduction: Bipolar disorder patients (BP) with comorbid Substance Use Disorder (SUD) may present clinical features that could compromise adherence and response to pharmacological treatment. The purpose of this study was to examine clinical and psychopathological features of BP with and without comorbid SUD in a real-world setting.
Methods: The sample was composed by 131 affective patients. Sixty-five patients were affected by Bipolar Disorder I (BP-I, 49.2%), 29 by Bipolar Disorder II (BP-II, 22.3%) and 37 by Cyclothymic Disorder (CtD, 28.5%), according to DSM-IV. Sixty-six patients were diagnosed for a comorbid SUD. All patients have been submitted to psychometric assessment with Hamilton Depression Rating Scale (HDRS), Hamilton Anxiety Rating Scale (HARS), Young Mania Rating Scale (YMRS), Global Assessment Scale (GAS), Social Adjustment Self-reported Scale (SASS), Quality of Life Scale (QoL), at baseline and repeated follow-up periods (1, 3, 6, 12 months).
Results: BP comorbid for SUD were more likely diagnosed as BP-II and CtD and were less likely to present a moderate–severe manic symptomatology. Furthermore, personality disorders were more frequent in SUD patients than in non-comorbid BP. BP with SUD were not different for primary outcome measure (HDRS, HARS, YMRS, GAS) from non-comorbid BP; however, BP with SUD were significantly more impaired in social functioning (SASS) at any stage of the follow-up and poor functioning increased the risk of relapse in substance use during treatment. Finally, SUD comorbidity did not represent a risk factor for treatment drop-out, while in our sample young age, low treatment dosage and BP-I diagnosis were significantly associated with drop-out.

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Discussion: The primary finding of this work is that BP with comorbid SUD are significantly more compromised in social functioning. Second, these patients were less likely to be diagnosed for BP-I and to present a severe manic symptomatology. Finally, we found that the diagnosis of SUD, but young age, low treatment dosage and BP-I diagnosis to be risk factors for treatment drop-out. Physicians should be alert to these differences in their clinical practice.

Keywords: Bipolar disorder; Substance use disorder; Substance abuse; Substance dependence; Social adjustment

1. Introduction

Bipolar Disorder (BP) is a severe and often chronic disorder with lifetime prevalence rates of bipolar spectrum disorders up to 6.5% in the general population (Vornik and Brown, 2006). BP patients frequently report co-occurring substance use disorders, and the rates of alcohol and other substance use disorders are significantly higher in persons with BP than in the general population (Vornik and Brown, 2006). In USA, the National Institute of Mental Health Epidemiologic Catchment Area Study found that 60% of patients with Bipolar I Disorder (BP-I) develop a Substance Use Disorder (SUD) in their lifetime; this comorbidity rate is higher than for any other Axis I disorder (Regier et al., 1990). More recently, the National Epidemiological Survey on Alcohol and Related Conditions reported an adjusted odds ratio of 3.5 for BP-I and any alcohol use disorder, and an adjusted odds ratio of 4.5 BP-I and drug use disorder (Grant et al., 2005).

Alcohol dependence is more strongly associated with any mood disorder than either problematic use or abuse, and BP is more strongly associated with any alcohol-related condition than either major depression or dysthymia (Regier et al., 1990). However, the precise nature of these associations remains uncertain and may reflect several different underlying mechanisms. Recently, it has been demonstrated that in comparison with major depression, BP-II was associated with the development of alcohol and benzodiazepine use and disorders and that manic symptoms, even when below current diagnostic thresholds for hypomania, may be a powerful risk factor for these disorders (Merikangas et al., 2008). Besides, it has been advanced the hypothesis that BP preceded by substance misuse may represent a clinically milder subtype of bipolar illness (Pacchiarotti et al., 2007).

BP patients with co-occurring SUD usually show a more severe course of the illness, characterized by higher rates of mixed or dysphoric mania, rapid cycling, increased symptom severity (Frye and Salloum, 2006) and poorer treatment outcomes due to a range of clinical and psychosocial factors that collectively impede remission and recovery (Goldberg et al., 1999).

Adherence with pharmacotherapy for the treatment of BP is critical to prevent the recurrence of affective episodes (Fleck et al., 2005). A highly prevalent subgroup of BP patients with an elevated probability of poor medication adherence is represented by individuals with a co-occurring SUD (Manwani et al., 2007).

Quality of life has gained increasing attention as an important component of functional outcome in bipolar and unipolar mood disorders (Goldberg and Harrow, 2005). In fact, recovery in BP should not be defined merely by symptomatic remission or even syndromal remission; rather, it should include symptomatic recovery, syndromal recovery, functional recovery, and a return to an acceptable quality of life for the patient (Harvey, 2006). Nevertheless, there is a lack of studies exploring social adjustment and quality of life in patients with BP, particularly in patients with co-occurring SUD.

The purpose of this study was to examine clinical and psychopathological features of BP with and without comorbid SUD in a real-world setting. Besides, since the majority of studies focusing on clinical outcome and response to treatment of BP with comorbid SUD were retrospective (Goldberg et al., 1999) or considered six months of follow-up (Farren and Mc Elroy, 2008) or small samples of patients (Strakowski et al., 2007), this study aims to examine clinical outcome of BP with SUD after one-year follow-up.

2. Patients and methods

2.1. Sample

Participants were recruited from June 2006 to December 2007 among outpatients referring to the Department of Psychiatry of the Catholic University of Sacred Heart of Rome. Inclusion criteria were: 1) currently meeting DSM-IV criteria for Bipolar Disorder I (BP-I), Bipolar Disorder II (BP-II) or Cyclothymic Disorder (CtD); 2) age 18 to 80 years. Participants were excluded if any of the following conditions was present: 1) a diagnosis of mental retardation or documented IQ < 70; 2) unstable general medical conditions; 3) clinically significant pre-study physical exam, electrocardiogram, laboratory or urinalysis