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The purpose of this study is to understand and describe the lived experience of adult bipolar patients with comorbid substance use disorder. About 5.7 million American adults or about 2.6% of the population age 18 and older in any given year, have bipolar disorder (NIMH, 2006). Substance use in patients with mental illness is prevalent and of national interest. Of particular concern is the high incidence of comorbid substance use in the bipolar population because co-occurring substance use in patients with bipolar disorder changes the illness presentation increasing the incidence and severity of manic or depressive symptoms (Frye & Sallolum, 2006).

A descriptive phenomenological approach was used. In-depth interviews were conducted with twelve adults. Interviews were audio-recorded and transcribed verbatim. Field notes were taken during the interviews and incorporated into written transcripts. Data were analyzed using Colaizzi's method. Significant statements were highlighted and placed into broad categories, which were then organized into themes. Findings were presented back to study participants to confirm that the findings represent their lived experiences.

Six distinctive themes were developed and validated by the descriptions of the experiences of the participants. The six themes that emerged from analysis of formulated meanings were: (a) It is hard; (b) Feeling the effects; (c) Trying to escape; (d) Spiritual support; (e) Being pushed beyond the limits; and (f) A negative connotation. All six

themes emerged from a phenomenological analysis of all participants' stories. No one theme was dominant but all the themes came from the interconnection of bipolar disorder and substance use disorder, or being dually diagnosed.

Findings from this study have implications for nursing practice, research and education. If nursing and health care professionals understand the problem as these patients perceive it, management of mood swings and relapses from periods of sobriety along with selection of treatment modalities will be improved.

THE LIVED EXPERIENCE OF ADULT BIPOLAR PATIENTS  
WITH COMORBID SUBSTANCE USE DISORDER

by

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## **CHAPTER I**

### **INTRODUCTION**

#### **Introduction**

The National Institute of Mental Health (NIMH) (2006) defines bipolar disorder as a severe psychiatric illness characterized by alternating manic and depressed mood states, with associated disturbances in energy levels, sleep, appetite, and cognition. Usually developing in late adolescence or early adulthood, some patients suffer for years before the disorder is diagnosed and treated. About 5.7 million American adults, or about 2.6 percent of the population age 18 and older in any given year, have bipolar disorder (NIMH, 2006).

Kraepelin (1921/1976) described the course of this illness systematically more than 80 years ago. He described manic-depressive illness as a recurrent “circular” psychosis involving mania and melancholia. He described manic-depression as having a fluctuating course, with periods of normality alternating with periods of illness. Bipolar disorder is considered one of the more serious mental illnesses. During episodes of depression or mania, basic functioning is often severely impaired in the most important life domains. A person may act in uncharacteristic ways and must later deal with the devastating interpersonal, financial, and other consequences. Hospitalization may be required, and psychotic symptoms may be experienced. Because bipolar disorder tends to follow a chronic, recurring course, jarring disruptions of one’s planned life course may

have to be dealt with. At its extreme, through suicide or dangerous behaviors, the illness may prove to be fatal.

The number of patients who have bipolar disorder is significant and growing. Additionally, a high prevalence of co-occurring substance use exists among persons with severe mental illness such as bipolar disorder. Bipolar disorder is the Axis I disorder with the highest rate of co-occurrence of substance use (Bizzarri et al., 2007; Chengappa, Levine, Gershon, & Kupfer, 2000; McKowen, Frye, Altshuler, & Gitlin, 2005; Regier et al., 1990). This has become a subject of increasing concern to the mental health community because adults with bipolar disorder and substance use disorder have increased risk for negative outcomes from their disease (NIMH, 2006). This includes damaged relationships, poor job or school performance and suicide (NIMH, 2006). Bipolar disorder (BD) is associated with a significant risk of attempted suicide (Hawton, Sutton, Haw, Sinclair, & Harriss, 2005; Valtonen et al., 2007). During their lifetime, 80% of patients with bipolar disorder exhibit suicidal behavior and 51% attempt suicide (Valtonen et al., 2005, 2007).

While research has demonstrated a high incidence of bipolar disorder and co-occurring substance use, little attention has been given to the individual perspective of the effected individuals themselves. It is important to understand the personal meaning of problems these patients face and the real significance to them so their specific needs can be addressed (Lim, Nathan, O'Brien-Malone, & Williams, 2004). A qualitative research study is needed to capture their perspective. Qualitative studies aim to enhance conceptualizations through description of lived experiences that have eluded many other

theories (Boyd & Munhall, 1993) Qualitative research reveals information about the subtleties and complexities of human responses to disease that are essential to the development of interventions (Sandelowski & Barroso, 2003). This study describes the lived experience of adult bipolar patients who have co-occurring substance use disorders. If nursing and health care professionals understand the problem as these patients perceive it, treatment and intervention plans may be influenced and implications for further research in this population may be identified.

### **Statement of the Problem/Scope of the Problem**

Mental disorders are common in the United States and internationally. An estimated 26.2% of Americans ages 18 and older—about one in four adults—suffer from a diagnosable mental disorder in a given year (NIMH, 2008). Within that number patients who have bipolar disorder is significant and increasing. In 2002 approximately 2.3 million American adults, or about 1.2 percent of the U.S. population age 18 and older, were affected by bipolar disorder (National Alliance on Mental Illness [NAMI], 2005). Today about 5.7 million American adults or about 2.6% of the population age 18 and older in any given year have bipolar disorder (NIMH, 2006).

The incidence of substance use is also significant in the United States. The National Survey on Drug Use and Health (2006) indicates that 9.2% of the population aged 12 or older was classified with substance use. Substance use is very common among people with bipolar disorder. As the number of individuals diagnosed with bipolar disorder continues to increase, so does the incidence of substance use disorder within this population.

There is evidence that the prevalence of substance use disorders in individuals with mental illness is highest in individuals with bipolar disorder. Most notably, Regier et al. (1990) studied the prevalence of comorbid alcohol, drug and mental disorders in the United States [the Epidemiologic Catchment Area (ECA) Study]. The study reported that bipolar disorder is the Axis I disorder with the highest rate of co-occurrence of substance use. The findings of this landmark study serves as a cornerstone for research studies of bipolar patients with substance use disorders. Studies that are more recent confirm these findings reporting a higher prevalence of comorbid substance use in bipolar patients (Bizzarri et al., 2007; Cassidy, Ahearn, & Carroll, 2001; Chengappa et al., 2000; Merikangas et al., 2007; McKowen et al., 2005; Sbrana et al., 2005; Weiss et al., 2004). The lifetime prevalence rate for any substance use in bipolar patients was 56.1% (Chengappa et al., 2000). The lifetime comorbidity between bipolar disorder and substance use disorder ranges between 17% and 61% (Bizzarri et al., 2007). Additionally among individuals seeking treatment for a mood disorder, approximately 20 percent have a comorbid substance use disorders (Grant et al., 2006).

This demonstrates the incidences of bipolar disorder and substance use disorder are increasing and significant. Clearly, such high rates of comorbid substance use in bipolar patients indicate the need for further research to provide an understanding of the problem. Additional research is needed to resolve uncertainties that are impediments to advancing the understanding of bipolar disorder and comorbid substance use disorder and its impact on role and social functioning (Chengappa et al., 2000; Merikangas et al., 2007).

Substance use in patients with bipolar disorder leads to negative mental and physical health outcomes. Co-occurring substance use in patients with bipolar disorder changes the illness, including presentation increasing the incidence of mixed or dysphoric mania, rapid cycling, increased symptom severity, and higher levels of novelty seeking, aggressiveness, and impulsivity (Frye & Salloum, 2006). There is also an increase in physical conditions related to alcohol use, such as peptic ulcer disease, liver disease, and pancreatitis in these patients (Arehart-Treichel, 2006). The increase in the negative effects on the presentation and course of bipolar disease leads to poor treatment response and compliance. This increases the risk for negative outcomes, including hospitalization, violence, legal problems, homelessness, victimization, HIV infection, hepatitis, overdose and suicide (Dalton, Cate-Carter, Mundo, Parikh, & Kennedy, 2003; McDermott, Quanbeck, & Frye, 2007; United States Department of Health and Human Service [U.S. DHHS], Substance Use and Mental Health Services Administration [SAMHSA], 2002.). This increase in negative outcomes, specifically overdose and suicide attempts, have a high potential for being lethal and result in an increase in death rates for these populations (Dalton et al., 2003; McDermott et al., 2007).

The primary social impact on patients with bipolar disorder and comorbid substance use disorder is stigmatizing attitudes held by family, friends and health care providers (Thornicroft, 2006). Stigma is one of the major barriers that discourage adults with mental illnesses and the families of children and adolescents with serious emotional disorders from seeking treatment (SAMHSA, 2003). Consequences of discrimination and stigma for adults who have mental illnesses such as bipolar disorder and substance use

disorders include lowered self-esteem, disrupted family relationships, increased difficulty in building connections in the community, securing housing, and obtaining employment (SAMHSA, 2003; Thornicroft, 2006).

Each year, more than 33 million Americans use health services to treat mental, alcohol, and other substance use and use conditions. The U. S. spends \$104 billion to treat mental illness and substance use, or about 7.6% of the \$1.4 trillion spent on personal health care (Druss, 2006). Individuals with bipolar disorder are faced with significant medical expenses associated with managing their disease. Studies have found that bipolar-related treatment costs are significantly higher when compared with non-bipolar individuals and patients with other psychiatric and non-psychiatric diagnoses, including depression and diabetes (Bryant-Comstock, Stender, & Devercelli, 2002; Peele, Xu, & Kupfer, 2003). High hospitalization rates among bipolar patients are one factor responsible for much of these cost discrepancies (Bryant-Comstock et al., 2002). Bipolar patients are also high medication users, which adds to overall treatment costs (Bhugra & Flick, 2005). One insurance claims review study found that bipolar disorder patients received an average of 15 central nervous system drug prescriptions annually (Bryant-Comstock et al., 2002). Bipolar disorder is also costly in loss of work productivity. In a study examining the cost of mood disorders, Kessler et al. (2006) associated bipolar disorder with a projected \$96.2 million in lost work days and \$14.1 billion salary-equivalent per year. The economic burden of bipolar disorder and comorbid substance use disorder is substantial and relevant to the care of this population because it influences access, treatment and management of the disease.

There are a multitude of factors that affect the health care and health needs of individuals with bipolar disorder and comorbid substance use disorder. The incidence of bipolar disorder, substance use disorder, and bipolar disorder with comorbid substance use disorder is increasing. This has a negative impact on the health care and health needs of these individuals. It also affects compliance with treatment and disease management. There are substantial social and economic implications for these individuals. The mental health nursing specialty, through nursing research at the NIMH (NIMH, 2006), is attempting to foster mental health and prevent mental illness as well as improve understanding, treatment and rehabilitation of the mentally ill (McBride, 2007). The federal government is attempting to improve services to address the complex task of developing prototype individualized plans to address the needs of this population (SAMHSA, 2006). This requires a creative marriage between protocol and outcomes development and the customization and clinical artistry inherent in the nurse-client therapeutic relationship (McBride, 2007; Shattell, Starr, & Thomas, 2007). This study is supported by the need to begin to understand how individuals with bipolar disorder and comorbid substance use disorder perceive the factors affecting their health care and health needs. Furthermore, this study is needed to begin to understand what treatment modalities and nursing implications are required to address the needs of this population. Nurses as well as other health care professionals want to grasp the lived experience of their clients, to enter into the world their clients inhabit, and understand the basic social processes that illuminate human health and illness events (Nieswiadomy, 2008; Speziale & Carpenter, 2007). There is little known about the lived experience of bipolar patients

with comorbid substance use disorder because The disorders are hard to quantify. A qualitative research approach can describe and interpret perplexing human phenomena that is not easily quantifiable (Krasner, 2000; Speziale & Carpenter, 2007).

### **Sensitizing Framework**

The theoretical framework that makes this researcher responsive to exploring the lived experience of adult bipolar patients with comorbid substance use disorder is based on Newman's theory of health as expanding consciousness (Newman, 1986). The theory of health as expanding consciousness was stimulated by concern for those for whom "health as the absence of disease or disability is not possible" (Newman, 1986, p. 7). Nurses often relate to such people facing the uncertainty associated with chronic illnesses such as bipolar disorder. The theory asserts that every person in every situation, no matter how disordered and hopeless it may seem, is part of the universal process of expanding consciousness—a process of becoming more of oneself, of finding greater meaning in life, and of reaching new dimensions of connectedness with other people and the world (Newman, 1994).

Exploring the lived experience of adults with bipolar disorder and comorbid substance use allowed the researcher to reveal behaviors that the participants experience.

According to Newman's theory "there is no basis for rejecting any experience as irrelevant. The important factor is to get in touch with one's own behavior and recognize that whatever it is, the process is in progress and the experience is one of expanding consciousness" (Newman, 1986, p. 67). This researcher views the experiences of the participants as relevant and believes that it is necessary for health care providers, families

and communities to be aware of the process of expanding consciousness of these individuals.

Newman's philosophical claim about behavior and disease purport that disease, when present is a manifestation of the whole and can provide insight into the human needs of the people (Newman, 1995). Exploration into the lived experience of adult bipolar patients with comorbid substance use disorder will provide insight into the needs of these individuals.

The task in intervention with illnesses such as bipolar disorder and comorbid substance use disorder is behavior recognition (Newman, 1986). As health professionals we are to look at behaviors among people to discern their expanding consciousness (Newman, 1994). The purpose of this research study was to bring focus and attention to the problem of bipolar disorder and comorbid substance use, gain insight into the behaviors that arrive from them, and identify how these behaviors manifest as health and emerge as expanded consciousness for the participants from their own perspectives.

### **Historical and Experiential Context of the Study**

The researcher's interest in studying the experiences of adult bipolar patients with comorbid substance use disorders evolved from both professional and personal experiences. During the researcher's professional career as a clinical nurse educator teaching an introductory psychiatric nursing course and as a clinical instructor in a state psychiatric hospital setting, the researcher frequently interacted with and observed the difficulties of adult bipolar patients with comorbid substance use disorders. Interactions with patients revealed the challenges associated with their condition and the significant

challenges they faced being understood. Additionally, in the spring of 2007, the researcher conducted a pilot research study to explore the lived experiences of mothers of adults with bipolar disorder. An existential qualitative design was utilized. In-depth interviews were conducted with three mothers. Four overall themes emerged from the three interviews: Fear of losing their child; perils of dealing with mental illness; a lack of understanding; and mothering. The study findings also revealed that mothers believed their adult bipolar children faced many challenges because of co-occurring substance use. The mothers stated they believed their children were self-medicating, drug seeking and experimenting with drugs. However, this perspective was that of the mothers, and the researcher believed the study lacked the perspective of the adult bipolar patients themselves.

### **Purpose Statement**

The purpose of this study was to understand and describe the lived experience of adult bipolar patients with comorbid substance use disorder. The study's aim was to bring focus and attention to the concerns of these individuals. This patient population is at risk for untoward events such as increased hospitalizations and suicides that create an urgent need for intervention and treatment. Gaining a sense of each participant's perspective of what it is like to live with bipolar disorder and comorbid substance use disorder is significant to knowledge development and policy development to meet the needs of these patients.

### **Research Question**

The research question is: What is the lived experience of adult patients with bipolar and a co-morbid substance use disorder?

### **Definitions of Terms**

The following definitions will be used for the purpose of this study:

Adult: For the purpose of this study, an adult will be an individual age 18 or older who are no longer considered a minor. The North Carolina General Assembly (2007) identifies age 18 as the age at which a child is no longer considered to be a minor.

Bipolar Disorder: There are a number of different definitions for bipolar disorder. The DSM IV-TR (2004) encompasses the classic definition of manic-depressive disorder and requires that the patient has had a manic episode to confirm the diagnosis. Diagnostic criteria for bipolar disorder include: the patient is or was recently in a manic episode. The patient has had at least one previous major depressive episode, manic episode, or mixed episode Diagnostic Statistical Manual (DSM IV-TR, 2006). NIMH (2006) defines bipolar disorder as a severe psychiatric illness characterized by alternating manic and depressed mood states, with associated disturbances in energy levels, sleep, appetite, and cognition. For the purpose of this study patients will meet the DSM IV-TR (2004) criteria and the definition by the NIMH will be used.

Comorbid: For the purpose of this study, comorbid is defined as the occurrence of bipolar disorder and substance use disorder at the same time (Center for Disease Control [CDC], 2007).

Dual Diagnosis: Refers to the situation in which somebody suffers from a mental disorder and is dependent or addicted to some substance (Telias, 2001).

Lived Experience: According to Speziale and Carpenter (2007), lived experience gives meaning to an individual's perception of a particular phenomenon. For the purpose of this study, the lived experience is how the person involved describes experiences in their world (Nieswiadomy, 2008).

Substance Use Disorder: When an individual persists in use of alcohol or other drugs despite problems related to use of the substance (substance dependence) or a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to repeated use of substances (substance use), it is considered substance use disorder (DSM-IV TR, 2006; Townsend, 2007).

### **Assumptions**

The assumptions for this study were:

1. The participants in this study are willing to talk about their experience.
2. It is possible to discover and understand how people make sense of what happens in their lives (Locke, Spirduso, & Silverman, 2007).

### **Delimitations**

1. Participants will be selected from communities in North Carolina.
2. Participants will be 18 years of age or older.
3. Participants will be able to participate in an interview, and will not be in significant emotional distress at the time of the interview.
4. Participants will meet DSM-IV TR criteria for bipolar disorder.

5. Participants will meet DSM-IV TR criteria for substance use disorder.

### **Significance of the Study**

Prevalence and occurrence of bipolar disorder and comorbid substance use disorder are well noted in the literature (Bizzarri et al., 2007; Cassidy et al., 2001; Chengappa et al., 2000; McKowen et al., 2005; Merikangas et al., 2007; Sbrana et al., 2005; Weiss et al., 2004). Additionally, there are studies aimed at identifying the reasons for substance use in bipolar patients (Bizzarri et al., 2007). However, there is limited information available about the experience of these individuals. This study was needed to fill the gap in knowledge that exists about the lived experience of adults with bipolar disorder and comorbid substance use disorder.

While there is little known about this population's lived experience, what is known is there are a number of social, economic, and political factors that affect these individuals. The principal social factors impacting their health care are intangibility, stigmatization and inequity in access to care (NIMH, 2001, 2003). Sometimes referred to as the invisible illnesses, the signs of these illnesses, unlike other conditions, do not entail a physical irregularity (NIMH, 2001). This makes it hard for people to understand and accept bipolar disorder and comorbid substance use as an illness. This affects not only whether people with bipolar disorder and comorbid substance use disorder will seek care but also where and when they will seek care. It also impacts the types of care chosen or provided, what happens during care, and outcomes of care for this population (NIMH, 2003).

It is also known that stigmatization results in a number of consequences that affect social interaction for this population. Consequences of discrimination and stigma for adults who have bipolar disorder and comorbid substance use disorder include lowered self-esteem, disrupted family relationships, increased difficulty in building connections in the community, securing housing, and obtaining employment (SAMHSA, 2007; Thornicroft, 2006). The effective treatment of comorbid substance use in bipolar patients is important in decreasing the associated medical and social consequences of these disorders (Cassidy et al., 2001).

The U. S. spent about \$85.4 billion dollars on mental health care in 2006 (SAMHSA), which spending accounts for approximately 6% of the nation's total health spending and about 0.84% of the U. S. gross domestic product. State and federal policy makers blame "out of control" mental health spending on budget problems (Frank & Glied, 2006). Productivity losses due to mental illness surpass \$60 billion annually (CMH, 2003; Druss, 2006). Mental disorders such as bipolar disorder and comorbid substance use disorder place an enormous emotional and financial burden on ill individuals and their families. They are also costly for our nation in reduced or lost productivity and in medical resources used for care, treatment, and rehabilitation. This study allowed the researcher to explore the experiences of individuals with bipolar disorder and comorbid substance use disorder and provide a knowledge base from which preventative measures can be inferred.

For more than 75 years, public health policy aimed at the improving health for the mentally ill has been emerging (NIH Legislative Chronology [NIH], 2006).

SAMSHA was created as a services agency to focus attention, programs, and funding on improving the lives of people with or at risk for mental and substance use disorders (U. S. Department of Health and Human Services [U.S. DHHS] and Substance Use and Mental Health Services Administration [SAMHSA], 2007). The establishment of SAMSHA has resulted in the development of a number of treatment models and funding for those with mental illnesses like bipolar disorder and co-occurring substance use. However, policies are needed to allocate funding, evaluate the treatment models and increase patient compliance with government programs. President George W. Bush established the President's New Freedom Commission on Mental Health in April 2002 as part of his commitment to eliminate inequality for Americans with disabilities. The President directed the Commission to identify policies that could be implemented by federal, state and local governments to maximize the utility of existing resources, improve coordination of treatments and services, and promote successful community integration for adults with a serious mental illness such as bipolar disorder and comorbid substance use disorder (CMH, 2003). This study explored the lived experiences of adults with bipolar disorders and comorbid substance use disorder and provided insight into their experiences with utilization of resources, treatments and community interaction.

Adults with bipolar disorder and comorbid substance use disorder are at risk for increased suicide attempts. Lifetime rates of suicide attempts for bipolar patients with comorbid substance use disorders is 39.5%, while the lifetime rate for bipolar patients without a substance use disorder is 23.8% (Dalton et al., 2003). This study explored the experience of bipolar patients with comorbid substance use and yield insight into factors

associated with suicide attempts that have both clinical and theoretical relevance. This information can save lives.

No qualitative studies have been conducted that explore the perspectives of individuals with bipolar disorder and comorbid substance use disorder. Exploring their experiences has provided information related to social, economic and political issues in this population. This will help conceptualize their experience and meet the goal of SAMHSA, which is to focus attention on improving the lives of people with or at risk for mental and substance use disorders (SAMHSA, 2007). This has important implications for individuals affected with bipolar disorder and comorbid substance use disorder and communities at large.

### **A Qualitative Approach**

Qualitative researchers typically seek to explore, understand, and represent the subjective experiences of people, and to make sense of and interpret their actions, experiences, and other social phenomena in terms of the meanings associated with them. Based on detailed accounts from informants and other sources of information, qualitative researchers attempt to develop a complex and holistic, yet multifaceted, conceptual picture of the phenomenon or area under study (Creswell, 1998). A qualitative research approach was selected for this study because it allowed the researcher to conduct an in-depth inquiry of the experience of adults with bipolar disorder and comorbid substance use disorder from the unique perspective of the individual. This was important because there was a gap in knowledge and understanding related to the lived experience of these individuals. Specifically this study was conducted using a phenomenological approach.

For this study, the researcher chose to use a phenomenological method, which does not use a pre-selected theoretical framework. The researcher refrained from applying positivistic scientific methods in an effort to allow the participant's perception of reality to emerge. Stubblefield and Murray (2002) propose that descriptive phenomenology, incorporating bracketing and participant validation, is appropriate and valuable for psychiatric nursing research because it allows for description of the unique nature of the clients' realities. Although the discussion is primarily related to the experience of being mentally ill, this researcher believes that Stubblefield and Murray's arguments are relevant to individuals who have bipolar disorder with a co-existing substance use disorder because the participant's unique realities will be described using this method.

Psychiatric illnesses have a less thorough inductive research base because the majority of the studies are conducted by medical, psychological, and sociological disciplines using experimental designs (Wade, 2006). Of the research studies conducted looking at patients affected by bipolar disorder and co-occurring substance use, the majority of researchers identify or discuss a quantitative approach for their studies (Bizzarri et al., 2007; Cassidy et al., 2001; Chengappa et al., 2000; McKowen et al., 2005; Merikangas et al., 2007; Sbrana et al., 2005; Weiss et al., 2004 ). A qualitative approach may reveal areas overlooked by previous quantitative studies. Additionally, an inductive research approach was important because it will allow key issues, themes and trends important to the participants in the study to emerge without imposing restraints of more deductive structured methodologies. This approach is in line with the client-

centered care focus as identified by the Institute of Medicine (Smedley, Stith, & Nelson, 2003).

### **Summary**

In Chapter I, an overview of the proposed study was provided. This study provides a unique and important contribution to nursing knowledge by allowing for a beginning understanding of the lived experience of adults with bipolar disorder and a comorbid substance use disorder. This chapter provided the purpose of the study and information to support the significance and limitations of the study, along with the sensitizing framework, and a brief overview of the methodology that was used.

## **CHAPTER II**

### **LITERATURE REVIEW**

#### **Introduction**

In the U. S., mental health and substance use problems and diseases are the leading cause of disability and death for women of all ages and the second highest cause for all men (SAMHSA, 2006; Smedley et al., 2003). The purpose of this chapter is to provide an overview of mental health and substance use problems in society as described in the literature. The chapter will focus on the issue of comorbid substance use in adults with bipolar patients. Additionally, the alternate approaches that have been used to understand bipolar disorder and comorbid substance use will be presented.

Scholars of descriptive phenomenology propose that researchers withhold an in-depth literature review prior to investigation in an attempt to neutralize personal biases, preconceptions and personal knowledge (Deutscher, 2001). Others question whether ignoring the literature makes sense when personal experience or bias cannot be summarily dismissed (Swanson-Kauffman, 1988). Another perspective of the literature review is that it serves as a source to neutralize personal bias (Wojnar & Swanson, 2007). A review of the literature is included in this study to assist the researcher in neutralizing personal bias and maintaining sensitivity to issues surrounding the problem of bipolar disorder and comorbid substance use. Additionally, the literature review will provide an overview of bipolar disorder and comorbid substance use for individuals reading this

study. A number of strategies were used to review the literature. Computer searches of the Cumulative Index to Nursing and Allied Health Literature, PsycInfo, Pub Med and Medline were used. Key terms used to identify relevant literature were substance use, substance use, bipolar disorder, comorbidity, dual diagnosis, perspective, lived experience, qualitative, psychology, sociology, medicine and nursing. Much of the background investigation includes multidisciplinary studies. Notably, much of the literature review is centered on research published in psychiatry literature as almost no published studies existed in nursing literature.

### **Bipolar Disorder**

Bipolar disorder is classified in the current Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, 2006) as a mood disorder. It is important to remember, however, that in addition to mood changes there is a range of significant cognitive, behavioral, and sensory components also involved in the condition. The diagnostic criteria first specify four types of mood episodes, the presence of which may lead to a diagnosis of bipolar disorder. These are major depressive episode, manic episode, mixed episode, and hypomanic episode.

A major depressive episode is characterized by symptoms of:

- Depressed mood most of the day, nearly every day
- Markedly diminished interest or pleasure in all or most activities, nearly every day
- Significant increase or decrease (when not dieting) in weight
- Sleep disturbances (insomnia, hypersomnia)

- Psychomotor changes (agitation or retardation)
- Low energy level or fatigue
- Inability to concentrate or make decisions
- Recurrent thoughts of death or suicidal ideation

At least five of these symptoms must be present for at least two weeks and always include either depressed mood or loss of interest or pleasure. Symptoms must be severe enough to cause clinically significant distress or impairment in occupational, social, or other important areas of functioning. A manic episode, on the other hand, is characterized by:

- Abnormally and persistently elevated, expansive, or irritable mood
- Inflated self-esteem or grandiosity
- Decreased need for sleep
- More talkative than usual or pressure to keep talking
- Flight of ideas or racing thoughts
- Distractibility
- Increase in goal-directed activity
- Excessive involvement in pleasurable activities that have a high potential for painful consequences

At least four of these symptoms must be present for at least a week and always include the elevated, expansive, or irritable mood. If mood is only irritable, at least five symptoms are necessary. Symptoms must be severe enough to cause marked impairment

in occupational functioning or in usual social activities or relationships with others, require hospitalization, or include psychotic features.

A mixed episode is one in which the criteria are met for both a manic episode and a major depressive episode nearly every day for at least a week. Symptoms must be severe enough to cause marked impairment in occupational functioning or in usual social activities or relationships with others, necessitate hospitalization, or include psychotic features. Mixed episodes are sometimes referred to as “dysphoric mania.”

A hypomanic episode is a milder form of a manic episode. It is characterized by the same symptoms as a manic episode, with several exceptions. The mood disturbance is “clearly different from the usual non-depressed mood” rather than “abnormal.” Symptoms must last at least four days rather than a week. Symptoms are not severe enough to cause marked impairment in social or occupational functioning, or to require hospitalization. Finally, a hypomanic episode does not include psychotic features.

Specific bipolar diagnoses are based on the presence or history of combinations of these four types of episodes. Bipolar disorder in its “classic manic-depressive form” (Akiskal & VanValkenburg, 1994) is called Bipolar I Disorder. Bipolar I typically involves a history of both manic and major depressive episodes. Bipolar I requires the presence of at least one manic episode, and may include depressed, mixed, or hypomanic episodes as well. Although some patients experience only a single episode, for most patients bipolar disorder is a chronic, recurring illness. Onset is usually in early adulthood, most commonly late teens to late twenties (Goodwin & Jamison, 1990). Diagnosis of bipolar disorder is not always clear or easy, and many patients receive other

diagnoses lasting months or years before the bipolar diagnosis is made (Lish, Dime-Meenan, Whybrow, Price, & Hirschfeld, 1994).

The social and personal costs of bipolar disorder can be high. The marked changes in mood, thinking, and behavior during episodes can have immediate and delayed consequences. An episode may include mood lability, financial extravagance, fluctuations in levels of sociability, sexual indiscretions, or violent behavior (Basco & Rush, 1996), for which one may have to “pay later.” Major life consequences reported by high percentages of those with the diagnosis include financial difficulties, divorce or relationship difficulties, losing jobs or dropping out of school, and injury to self or others (Lish, et al., 1994). Substance use is also highly associated with bipolar disorder.

Despite these common problems, most people with bipolar disorder return to a fully functional level between episodes (American Psychiatric Association, 1994). Many, after taking time off during an episode, return to jobs and perform as well as they had before the episode. Some function at particularly high levels of productivity and creativity (Jamison, 1993). Even during non-symptomatic periods, however, many people with bipolar disorder are still dealing with implications of their illness. They may be “cleaning up” the results of uncharacteristic behaviors during an episode; they may experience worry or concern about the future course of the illness; they may actively monitor possible symptoms or problematic situations to try to avoid or mitigate recurrences. Some people with bipolar disorder do not experience periods of full recovery. According to the DSM-IV- TR (2004), about 20-30% continue to display mood lability and interpersonal or occupational difficulties (American Psychiatric Association,

1994). Other studies estimate even higher percentages with continued psychosocial impairment (Callahan & Bauer, 1999).

### **Substance Use Disorder**

Substance use disorder is a behavioral disorder characterized by preoccupation with obtaining alcohol or other drugs and a narrowing of the behavioral characteristics towards excessive consumption and loss of control over consumption. It is usually also accompanied by the development of tolerance, withdrawal and impairment in social and occupational functioning (DSM-IV TR, 2004). Substance use disorders are classified into two types, substance dependence and substance use.

Substance dependence is defined as a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

- Tolerance, as defined by either of the following:
  - Need for markedly increased amounts of the substance to achieve intoxication or desired effect. Markedly diminished effect with continued use of the same amount of the substance.
- Withdrawal, as manifested by either of the following:
  - The characteristic withdrawal syndrome for the substance.
  - The same or a closely related substance is taken to relieve or avoid withdrawal symptoms.
- The substance is often taken in larger amounts or over a longer period than was intended.

- There is a persistent desire or unsuccessful efforts to cut down or control substance use.
- A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects.
- Important social, occupational, or recreational activities are given up or reduced because of substance use.
- The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption) (DSM-IV-TR, 2006).

Substance use is defined as a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

- Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance related absences, suspensions or expulsions from school; neglect of children or household).
- Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use).

- Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct).
- Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).

There are a number of substances involved in substance use disorders.

- Alcohol : wine, beer, liquor, whiskey, gin, vodka
- Amphetamines : Benzedrine, Dexedrine, methamphetamine, crystal, ice
- Caffeine : coffee, cola
- Cannabis : marijuana, hash, has oil
- Cocaine : crack
- Hallucinogens : LSD-25, psilocybin, mescaline,
- Inhalants : nitrous oxide, glue, gasoline
- Nicotine : cigarettes, snuff, chewing tobacco
- Opioids analgesics : opium, morphine, heroin, codeine, fentanyl, Demerol
- Phencyclidine : PCP
- Sedatives, hypnotics or anxiolytics : barbiturates, Ambien, Valium, Librium, Tranxene, etc.
- Other : MDMA aka Ecstasy (DSM-IV-TR, 2006).

### **Substance Use and Mental Illness**

People with co-occurring substance use disorders and mental disorders are defined as experiencing the occurrence of both conditions at the same time (CDC, 2007). Co-occurring substance use disorders and mental disorders are both a common and highly complex phenomena that have been estimated to affect from 7 to 10 million adult Americans in any one year (NAMI, 2003; NIDA, 2007; SAMSHA, 2006). A significant lack of prevalence data on co-occurring disorders exists. The best data available on the prevalence of co-occurring substance use disorders and mental disorders are derived from two extensive surveys conducted and analyzed over the past two decades. The Epidemiologic Catchment Area (ECA) Survey, initially administered in the period 1980 to 1984 (Regier et al., 1990), and the National Comorbidity Survey (NCS), administered between 1990 and 1992 (Kessler et al., 1994). Both surveys document high prevalence rates for co-occurring substance use disorders and mental disorders in the general population. Although the findings for these studies are more than 10 years old, they served to quantify the problem of mental disorders and substance use. These two major studies established the foundational data for research in this area of study. Currently the findings of these studies continue to be supported by more current research and they serve as the background data for a number of studies into mental disorders and comorbid substance use disorder.

The ECA Survey focused on five geographical areas, assessed substance use disorders, and mental disorders in more than 20,000 people living in the community and in various institutional settings such as psychiatric hospitals, nursing homes, and jails or

prisons. It provided the nation's first quantitative information on co-occurring disorders. The NCS, a nationally representative, face-to-face household survey carried out between 1990 and 1992, was designed to build upon the results of the ECA Survey. The NCS estimates are based on a stratified, multistage area probability study of people age 15 to 54 years in the non-institutionalized population. The survey examined prevalence rates for co-occurring substance use disorders and mental disorders, as well as the temporal relationship between these disorders and the extent to which 12-month co-occurrence is associated with service utilization (Kessler et al., 1994).

Results of the NCS support the high prevalence rates for co-occurring substance use disorders and mental disorders among the general population described in the ECA Survey. The results also confirm the increased risk for people with either a substance use disorder or mental disorder for developing a co-occurring disorder. Results of the NCS support the high prevalence rates for co-occurring substance use disorders and mental disorders among the general population described in the ECA Survey. The results also confirm the increased risk for people with either a substance use disorder or mental disorder for developing a co-occurring disorder. The NCS found that:

- 42.7 percent of individuals with a 12-month addictive disorder had at least one 12-month mental disorder.
- 14.7 percent of individuals with a 12-month mental disorder had at least one 12-month addictive disorder.

The ECA Survey found that individuals with severe mental disorders were at significant risk for developing a substance use disorder during their lifetime. In particular:

- 47 percent of individuals with schizophrenia also had a substance use disorder (more than four times as likely as the general population).
- 61 percent of individuals with bipolar disorder also had a substance use disorder (more than five times as likely as the general population).

Estimates from both studies reveal that during a 12-month period, 22 to 23 percent of the U. S. adult population (44 million people) had diagnosable mental disorders (SAMSHA, 1999). About 15 percent (approximately 6.6 million) of adults with a diagnosable mental disorder had a co-occurring substance use disorder (SAMSHA, 2002).

The 2001 National Household Survey on Drug Use (NHSDA), for the first time in the Survey's history, included questions for adults and youth that measured serious mental illness (SAMHSA, 2002). The survey found a strong relationship between substance use disorders and mental problems. According to the now-named National Survey on Drug Use & Health [NSDA] (SAMHSA, 2006), there were an estimated 24.9 million adults aged 18 or older in the U. S. with serious mental illness or severe psychological distress (SMI/SPD) in 2006. This represents 11.3 percent of all adults in this country. Among adults aged 18 or older with SMI, 22.3 percent were dependent on or used illicit drugs or alcohol. The rate among adults without SPD was 7.7%. This study estimates that 5.6 million adults have co-occurring severe mental illness and substance use disorder. This is the most recent data on prevalence and correlates of substance use, serious mental illness, related problems, and treatment in the civilian population aged 12 or older in the U.S.

The literature identifies self-medication as the primary motivator for substance use in mentally ill patients (Judd et al., 2002, Kasten, 1999; Khantzian, 1997; Weiss et

al., 2004). Consistent use of substances according to Sbrana et al. (2005) can be considered self-medicating. Sbrana and his colleagues evaluated the prevalence of threshold and subthreshold use of substances among patients with psychiatric disorders in two comparison groups. Participants were outpatients and inpatients with mood and anxiety disorders, subjects with opiate dependence, and a comparison group of individuals not undergoing treatment for psychiatric disorders. The overall frequency of substance use disorder and that of subthreshold use were 46 percent and 8 percent in patients with bipolar disorder. Regular use of multiple substances was common among patients with bipolar disorder. Self-medication accounted for the use of substances 92 percent of the time among 27 patients with bipolar disorder. The pattern of motivations for use varied according to the psychiatric disorder. Results suggest a well-established relationship between substance use disorders and psychiatric disorders. This relationship, which begins with an increased proneness to substance use, leads to self-medication and may eventually develop into substance use or dependence among subjects with psychiatric symptoms.

Kasten (1999) conducted a qualitative study examining the experience of mentally ill adults with co-occurring substance use disorders in 20 dually diagnosed persons in recovery. Participants cited self-medication of psychiatric symptoms as an important motivation for substance use. Almost one third of the sample described using drugs or alcohol to relieve periods of depression. One participant in the study stated, "It wasn't to get drunk, it was to self-medicate me, to make me forget . . . just all of the use, and the feelings of depression and the feeling of suicide." Limitations of this study were that it

did not focus on the experiences of patients with particular classifications of mental illness such as bipolar disorder. A review of the literature reveals that symptom management is a common cause for substance use behaviors in patients with mental illness such as bipolar disorder. However, there is no research data available which identifies behaviors or patterns of experiences of adult bipolar patients with comorbid substance use disorder.

In conclusion, these studies have identified high rates of substance use among individuals being treated for mental illness and high rates of mental illness among individuals being treated for substance use. This has generated a number of replications of these studies (Kessler, Chiu, Delmer & Walters, 2005; Kessler & Merikangas, 2004; Merikangas et al., 2007, 2008). As a result, national concern about substance use and mental illness continues to grow, focusing on identifying trends, and health needs of those affected. These trends include comorbid substance use in select populations, such as adults with bipolar disorder, and identification of motivators for substance use disorder in the mentally ill population.

### **Comorbidities of Bipolar Disorder**

Persons with bipolar disorder are often afflicted with an additional disease. These comorbid conditions, which can be psychiatric or medical, can severely impact the overall health of the individual and intensify the severity of each condition. The coexistence of other Axis I disorders with bipolar disorder complicates psychiatric diagnosis and treatment (Bizzarri et al., 2007; Levin & Hennessy, 2004; SAMHSA,

2006). Examples of these include anxiety disorders, substance use disorder, headaches and multiple sclerosis.

Krishnan (2005) conducted a review of the literature which synthesized the available knowledge on both psychiatric and medical comorbidities of bipolar disorder. Articles were prioritized for inclusion based on sample size, diagnostic criteria, methods of assessment, sequencing of disorders and quality of presentation. Findings of the review reported rates of lifetime psychiatric comorbidity in bipolar I patients was 50 to 70%. Except for substance use disorders, medical and psychiatric comorbidity was more common in women than in men and adversely affected the recovery more often in women. Comorbid substance use in bipolar I disorder ranged from 6 percent to 69 percent for alcohol use, with rates of at least 30% in most studies, and from 14% to 60% for drug use (Cassidy, Ahearn & Carroll, 2001; Krishnan, 2005). Those who met criteria for lifetime bipolar I disorder also met criteria for a lifetime anxiety disorder, including social phobia, post-traumatic stress disorder and panic disorder (Chen & Dilsaver, 1999; Freeman, Freeman & McElroy, 2002).

A number of medical disorders were found to coexist with bipolar disorder. Medical disorders identified in the literature review were migraine headaches, at a prevalence rate of 15.2 percent, multiple sclerosis at a rate of more than 10 percent in multiple sclerosis patients, and Cushing's syndrome (Low, Du Fort & Cervantes, 2003; Minden, 2000; Sonino & Fava, 2001). The analysis concluded that the majority of patients with bipolar disorder I and II, of all ages and both genders, had at least one comorbid psychiatric or medical disorder. Krishnan (2005) states this awareness should

lead to ongoing research to shed light on the implications of Axis I comorbidity in bipolar disorder. Researchers were also encouraged to be vigilant and more thorough in assessment of patients with these disorders and individualization of treatment planning to meet the health needs of these patients. Optimal management of bipolar disorder demands awareness of comorbidities and the complications thereof (Krishnan, 2005). This research study contributes to increased awareness and a more thorough assessment of the health needs of this population.

### **Comorbid Substance Use in Bipolar Patients**

Adults with bipolar disorder and comorbid substance use represent a major public health problem. Substance use generally predicts poorer outcomes and higher morbidity/mortality in patients with bipolar disorder (Albanese & Pies, 2004; Bizzari et al., 2007; Reiger et al., 1990). A number of studies have examined comorbid substance use and bipolar disorder.

Albanese and Pies (2004) reviewed the epidemiology of substance use disorders and bipolar disorder, outlined the assessment and diagnosis of patients with such comorbidity, and discussed the treatment implications in individuals with comorbid substance use disorders and bipolarity. Their review of open and controlled studies of dual diagnosis, assessment and treatment revealed higher rates of drug use and alcohol use in patients with bipolar I disorder than in the general population. It was also noted that bipolar disorder in the general population was either misdiagnosed or underdiagnosed, with underdiagnosis being more common in bipolar patients with comorbid substance use. The review concluded that comorbid bipolar disorder and

substance use must be treated vigorously in order to maintain the patient's stability and quality of life. Study implications called for an integrated approach involving both pharmacotherapy and psychosocial intervention.

To determine the rates of clinically diagnosed alcohol and drug use in bipolar patients and examine the relationship with sex, age, episode subtype and clinical course, Cassidy, Ahearn and Carroll (2001) conducted a study of 392 bipolar patients. The study evaluated bipolar patients over a span of six years. The participants all met the Diagnostic Statistical Manual IV (DSM-IV TR, 2004) criteria for manic or mixed bipolar episodes. The study reported the overall rates of lifetime and active substance use in manic and mixed bipolar patients and comparisons by diagnostic subtypes (pure versus mixed manic) and sex. Demographic and clinical comparisons of subjects with and without lifetime comorbid substance use were also reported. Analysis was done using chi-square statistics. Rates of substance use were high, with a 48.5 percent rate for lifetime alcohol use, a 43.9 percent rate for lifetime drug use and a 59.4 percent rate for lifetime drug or alcohol use. A lifetime history of substance use was more common among males than among females. Rates of active substance use varied across the age groups. Clinical course indicators were lifetime psychiatric hospitalizations (6.8), age of first lifetime hospitalizations (26.4) and years since first psychiatric hospitalization (11.7). The study identified substance use as a major comorbidity in bipolar patients with nearly 60 percent of the cohort having a lifetime history of some substance use. These findings were similar to those of the ECA study. However, ascertainment of data from informants who may be less aware of the extent of usage is a limitation of the study. Cassidy, Ahearn

and Carroll (2001) call for future studies of the interaction of these disorders and the impact of substance use on the long-term outcome of bipolar disorder.

Strawkowski and Delbello (2000) examined four alternative hypotheses that might explain the common association between bipolar and substance use disorders. The researchers hypothesized that (a) substance use occurs as a symptom of bipolar disorder; (b) substance use is an attempt by bipolar patients to self-medicate symptoms; (c) substance use causes bipolar disorder; and (d) substance use and bipolar disorders share a common risk factor. Each of these hypotheses predicted certain relationships between substance use and bipolar disorder and were tested using data from the current literature. The researchers concluded that substance use and bipolar disorder co-occur more commonly than expected, and the specific reasons for this are unknown. A limitation of the study is the limited exploration of the role stressful life events have on patients with both bipolar and substance use disorders that conceivably underlie both. Another limitation of the study is the fact that findings were supported and tested by review of literature which in most instances was more than ten years old.

Weiss et al. (2000, 2004) investigated reasons for substance use and perceived substance-induced improvement in bipolar disorder symptoms among patients with current bipolar disorder and substance dependence by looking at 45 patients in a new group treatment program. During the admission interview, patients were asked about typical reasons for initiating use of their primary substance of use. The findings of the study indicate that nearly all patients initiated substance use because of at least one bipolar disorder symptom, with 35, or 77.8% of patients citing depression as that

symptom. One limitation of the study was the small sample size and possible recruitment bias, which precluded the researcher's ability to adequately examine important issues related to substance use and experienced symptoms of bipolar disorder.

Bizzarri et al. (2007) conducted a descriptive quantitative study to examine the spectrum of alcohol and substance use, including reasons for use in patients with bipolar disorder, in 104 patients diagnosed with bipolar disorder and co-occurring substance use disorder. Data were collected using structured clinical interviews. The study explored the use of substances and non-prescribed drugs in order to relieve symptoms related to mood, anxiety, eating disorders, or body dysmorphic disorder; to increase performance; and to enhance sensorial perceptions. Additionally, the study investigated sensation seeking or the tendency to seek strong emotions. Patterns of substance use in bipolar disorder identified the most frequently used substances, which were alcohol (68 percent), marijuana (61%), sedatives/hypnotics (25%) and cocaine (30%). Reasons for substance use identified were to alleviate mood/anxiety symptoms, to achieve or maintain a sense of euphoria and to increase energy. Patients in this study reported more generic reasons for substance use, such as alleviating boredom, relaxing after work, escaping from reality, and improving performance. The study also demonstrated a relationship between high sensation seeking and alcohol use or dependence in bipolar patients. The researcher concluded that substance sensitivity and sensation-seeking traits should be investigated in all patients with bipolar disorder in order to warn them of the risk associated with substance use and improper use of medications. One limitation of the study identified by the researchers was the use of a structured interview, which did not include open

questions and forced the patients to select from a range of motivations that may not have been exhaustive.

Merikangas et al. (2008) of the NIMH Mood and Anxiety Disorders Program collaborated with colleagues to conduct a long-term study of 591 people with manic symptoms and bipolar disorder. The aim of the study was to examine the degree to which major depression and bipolar conditions along the spectrum of the disorder may increase the risk for later onset of substance use disorders, and to assess the degree to which the patterns of comorbidity correlated with mood states. The results of the study revealed a strong association between bipolar disorder and the development of an alcohol problem or benzodiazepine use problem. The findings confirm a link between mood disorders and substance use or dependence problems. The researchers also suggest that earlier detection of bipolar symptoms could help to prevent consequent substance use problems. The study was conducted over a 20-year period of time. The study's participant attrition rate and the setting being a community in Zurich, have implications for the generalization of the study's results to other populations.

Quantitative studies conducted over the past ten years have provided a base in the study of bipolar patients with comorbid substance use disorder. Nevertheless, there is limited information regarding the patient's perceptions of the problem of bipolar disorder and comorbid substance use, and living with these disorders. This indicates a need for the current research study, which focuses on these patients' exhaustive explanations of their problem. The study allowed them to provide their perspective of the problem of bipolar disorder and comorbid substance use and assist them in being understood.

### Summary

The literature review supports substance use in patients with mental illness is prevalent and of national interest. Of particular concern is the high incidence of comorbid substance use in those with bipolar disorder. The literature demonstrates that individuals with bipolar disorder have the highest rates of comorbid substance use.

Nursing plays a major role in the health care of patients with mental illnesses such as bipolar disorder and substance use disorders (Goossens, Achterberg, & Knoppert-van der Klein, 2007; McBride, 2007; Miller, 2006; Tugrul, 2007). Nursing research has put a greater emphasis on the nurses' role in treatment and management of these clients. To date, no studies have examined the meaning of living with bipolar disorder and comorbid substance use. The literature review supports the need for capturing the lived experience of these individuals and assisting in developing an understanding of their illness as essential in addressing the treatment needs of these patients.

Therefore, a promising area of research is a qualitative approach that investigates the patients' perceptions of living with bipolar disorder and comorbid substance use. This under-studied phenomenon was explored and provides an opportunity for patients to talk freely about their experience and hence be understood. The following chapter will discuss the methodology, method and design used in this study.

## **CHAPTER III**

### **METHODOLOGY, METHOD, AND DESIGN**

#### **Introduction**

The purpose of this study was to explore the lived experience of adults with bipolar disorder and comorbid substance use disorder. This chapter will provide an overview of the significance of qualitative research and describe the researcher's rationale for use of a qualitative methodology to guide the study. In addition, it will also discuss the design of the study, role of the researcher, data collection and analysis processes, and issues of validity and reliability.

#### ***Significance of Qualitative Research***

Benotiel (1984) has described qualitative research as a mode of systematic inquiry concerned with understanding human beings and the nature of their transactions with themselves and with their surroundings. According to Creswell (1998) a qualitative study is defined as an inquiry process of understanding a social or human problem. Qualitative studies also are tools used in describing the world of human experience (Myers, 2000). Qualitative research is defined as a method of inquiry that takes an "interpretive and naturalistic approach to its subject matter" (Denzin & Lincoln, 1994, p. 2). Qualitative researchers typically seek to explore, understand, and represent the subjective experiences of people and make sense of and interpret their actions, experiences, and other social phenomena in terms of the meanings associated with them. Investigators

seeking to develop knowledge, which embraces ideals of holistic nursing, are often challenged with trying to understand human experiences in health and illness (Wojnar & Swanson, 2007). Based on detailed accounts from informants and other sources of information, qualitative researchers attempt to develop a complex and holistic yet multifaceted, conceptual picture of the phenomenon or area under study (Creswell, 1998). Data are often collected through interviews, focus group discussions, observations, documents or archival data, and audio-visual materials. Thereafter, the data are examined for meaningful categories or themes. Based on these categories or themes, the qualitative researcher may develop a theory, model, or description of the main issues that emerge from the data.

A qualitative research approach had several advantages for the purpose of this study. This study has overcome the limits of quantitative methods and allowed the researcher to conduct an in-depth inquiry into the lived experience of adults with bipolar disorder and comorbid substance use disorder. The study was conducted using a descriptive phenomenological approach. In phenomenologic studies, one strives to present a description and possibly an interpretation of the meaning of an experience with a specific phenomenon. Descriptive phenomenology stimulates our perception of lived experience while emphasizing the richness, breadth and depth of the experiences (Spiegelberg, 1975). The lived experience itself is used to provide universal description of the phenomenon (Tymieniecka, 2003). Descriptive phenomenology has its emphasis on describing universal essences. It calls for the exploration of phenomena through direct interaction between the researcher and the objects of study (Wojnar & Swanson, 2007).

This was the method of choice in the study because it allowed the researcher to gain a clearer understanding of the lived experience of adults with bipolar disorder and comorbid substance use disorder. Additionally, the researcher was able to draw conclusions from the participants in the study, allowing these conclusions to generate meaning for their experiences.

### **Evolution of the Descriptive Phenomological Approach**

What can be known, who can be the knower and whether subjective truth can be thought of as knowledge are the basic questions of epistemology. From the novice to the expert, from the bedside nurse to the researcher, epistemology is a fundamental way in which we study how we come to know what we know and what our knowledge is based on in nursing practice. There is a vast array of positions on knowledge that could lead to the suggestion that knowledge is not at all possible, that it is impossible to know anything. This is contrary to the phenomenological mode of thought in which where the knower and the known cannot be separated (Pollio, Henley & Thompson, 1997). The worldview of phenomenology accepts that truth can be revealed through the words of those that live the experience and describe the essence of that lived experience (Thomas & Pollio, 2002).

Edmund Husserl is considered the founder of phenomenology as a philosophy and the descriptive approach to inquiry (Benoist, 2003; LaVassueur, 2003; Maggss-Rapport, 2000; Wojnar & Swanson, 2007). Husserl's basic premise was that consciousness was the condition of all human experience. He sought to explain how to overcome personal biases, which stand in the way of achieving the state of pure consciousness. Husserl's

insight established a new philosophy and a new approach to scientific inquiry (Moran, 2000; Wojnar & Swanson, 2007). Husserl posits that the description of the lived experiences of individuals can be considered scientific and generalizable when strict adherence to the principles of descriptive phenomenology is employed and commonalities among research participants are identified.

### **Overview of the Methodology of Phenomenology**

The essential steps outlined in the descriptive phenomenology of inquiry include (a) bracketing, (b) analyzing, (c) intuiting, and (d) describing (Colaizzi, 1978; Swanson-Kauffman & Schonwald, 1988). Each of these steps is considered a key component of descriptive phenomenology. Additionally, it is believed that each moment of the investigation involves a blending of bracketing, analyzing, intuiting, and describing to produce a true understanding of the phenomenon under study (Swanson-Kauffman & Schonwald, 1988; Wojnar & Swanson, 2007).

#### ***Bracketing***

One of the central concepts of phenomenology is bracketing. The process of bracketing allows the researcher to (a) separate the phenomenon from the world, (b) dissect the phenomenon and unravel it, (c) suspend all preconceptions regarding the phenomenon and confront the subject matter on its own terms to assure preconceived ideas are held in abeyance while he or she is listening to, interacting with, and analyzing the participant stories (LeVasseur, 2003; Wojnar & Swanson, 2007). Phenomenologists believe it is essential to see the lived experience of research participants as they are, not filtered by previous knowledge, values, and beliefs. The researcher must be on par with

the participants and communicate receptivity, a willingness to be taught by participants, and openness to feedback (Thomas, & Pollio, 2002). The researcher entered into this study accepting that she had strong values, ideas and a personal commitment to individuals with bipolar disorder, substance use disorder and dual diagnosis. The researcher examined her feelings and her history with the phenomenon. A literature review was conducted to capture others' interpretations and neutralize bias. There was an expectation that a connection with the participants experiencing the phenomenon would be made. Writing down what was expected and the feelings about these expectations were captured through daily journaling. Conversing with colleagues about disqualifying findings from other studies helped clear some preconceived notions. The sensitizing framework used allowed the researcher to keep an open mind, and to believe that from participants descriptions of their behaviors something new could evolve. These activities allowed the researcher to declare her ideas, and deliberately approach data with an open mind.

### *Analyzing*

The second component of the descriptive phenomenological investigation is rigorous analysis. Colaizzi's (1978) method consists of seven steps and may be used to guide the analysis. Colaizzi's seven steps are:

1. Reading and rereading the participants' descriptions of the phenomenon to acquire a feeling for their experience and make sense of their account.
2. Extracting significant statements that pertain directly to the phenomenon.

3. Formulating meanings for these significant statements. The formulations must discover and illuminate meanings hidden in the various contexts of the investigated phenomenon.
4. Categorizing the formulated meanings into clusters of themes that are common to all participants; referring these clusters to the original transcriptions for validation and confirming consistency between the investigator's emerging conclusions and the participants' original stories; not giving into the temptation to ignore data which do not fit or prematurely generating a theory which conceptually eliminates the discordance in findings thus far.
5. Integrating the findings into exhaustive description of the phenomenon being studied. Employing a self-imposed discipline and structure to bridge the gaps between data collection, intuition and description of concepts. Describing includes coding segments of text for topics, comparing topics for consistent themes, and bridging themes for their conceptual meanings. Based on this description, a prototype of a theoretical model about the phenomenon under investigation is formulated.
6. Validating the findings by returning to some participants to ask how it compares with their experiences.
7. Incorporating any changes offered by the participants into the final description of the essence of the phenomenon (Colaizzi, 1978, 48-71).

### ***Intuition***

In the analysis of the participant's words and through noted observations of body language, tone and pitch of voice, the researcher is required to use a certain amount of intuition (Wade, 2004). Data generated from participant accounts nourish the investigator's intuition through attentive listening, deep critical reflection about commonalities across participants, and a concerted effort to understand "what it must be like." The intuitive process leads to the investigator owning a sense a personally having the participants' lived experience (Wojnar & Swanson, 2007). Intuiting balance with bracketing involves a conscious attempt to honor insights about emerging evidence while simultaneously refraining from premature researcher assumptions regarding the emerging concepts (Swanson-Kauffman & Schonwald, 1988).

### ***Describing***

The final step of descriptive phenomenological investigation is to present a theoretical model representing the essential structures of the phenomenon under study (Colaizzi, 1978). This study when describing the perspectives of the participants produced a description of the essential structures of the lived experiences of adults with bipolar disorder and comorbid substance use disorder.

### **Rationale for Use of Phenomenology**

The researcher's rationale for choosing a descriptive phenomenological method for the study was that it is consistent with her worldview of holistic nursing, which draws from patients' experiences, emotions, beliefs and values. The descriptive phenomenological method is congruent with this worldview as it values individualism

and the experience of the individual (Cowling, 2000; Wade, 2006; Wojnar & Swanson, 2007).

While many scientists argue that experimental designs are more valuable than qualitative designs, the richness of human experience can be lost in quantitative studies. Quantitative studies may tend to leave out valuable experiences, empathy, and the feelings of participants and tend to presume causal relationships. Phenomenology does not attempt to explain or predict, however; it attempts to illuminate. This is important in attempts to identify the concerns of these individuals. This researcher's self-reflection reveals a desire to seek similarities in human experiences, look for patterns, seek universals, and ultimately find solutions. This researcher believes that an individual can interpret and give meaning to his or her own experiences. Therefore, a descriptive phenomenology approach is the most suitable for this study. Bracketing will help this researcher receive meaning and interpretations and temporarily remove her preconceived notions.

### **Phenomenology: A Nursing Perspective**

Nursing scholars including Watson (1999), Parse (1998) and Koloroutis (2004) believe that to promote restore and maintain healing and wholeness, nurses must go beyond physical ministrations and encompass understanding of patient needs (Wojnar & Swanson, 2007). The phenomenological approach is compatible with these nursing values and allows nurse researchers to embrace ideas that allow for a clearer understanding of the human experience of illness. More importantly, it helps those caring (nurses) and

being cared for (patients) identify their needs as they come together in a contemporary health care setting.

In summary, phenomenology focuses on how we put together the phenomena we experience, which allows one to make sense of the world and, in so doing, develop a worldview (Patton, 2002). Descriptive phenomenology is a philosophical method of inquiry that allows the researcher to define and give meaning to the phenomenon under investigation. Additionally, descriptive phenomenology describes in scientific terms the uniqueness of consciousness and human existence. For these reasons, descriptive phenomenology is useful in guiding research studies today.

## **Methods**

### ***Characteristics of Sample and Selection Process***

A purposive sampling plan was used to identify participants for the study. This was essential because a sample in a phenomenological study is drawn from a population that has experience with the phenomena of concern (Nieswiadomy, 2008; Patton, 2002). The participants in this study had the personal experience of being an adult with bipolar disorder and comorbid substance use disorder. The study examined adult bipolar patients with co-morbid substance use disorders living in central North Carolina.

The Alcohol and Drug Council of North Carolina (2005) states that 860, 473 North Carolinians use and are addicted to some type of alcohol or drugs. In qualitative research, sample size is dependent upon the scope of the research question (Morse, 2000). Thus, interviews were conducted until the researcher concluded that no new information was being gathered. The point at which this occurs is referred to as saturation (Creswell,

1998; Nieswiadomy, 2008). Data analysis revealed that saturation in this study was reached after nine interviews. Three additional interviews were completed to ensure redundancy of the data. In the additional interviews of participants the same themes emerged and it was concluded that saturation had been met. In an effort to increase participant gender diversity, additional attempts to recruit were made during data analysis. The researcher was not able to recruit additional participants. The inclusion and exclusion criteria are listed in Table 1.

**Table 1**

***Inclusion and Exclusion Criteria for Adults with Bipolar Disorder and Comorbid Substance Use Disorder***

<b>Inclusion Criteria</b>	<b>Exclusion Criteria</b>
English speaking	Non-English speaking
Adult 18 years of age or older	Individuals under 18 years of age
Live in communities in Central/Regional North Carolina	Individuals cognitively impaired
Meets criteria of DSM-IV diagnosis of bipolar disorders	Individuals in significant emotional distress
Meets criteria of DSM-IV diagnosis of substance use disorder	

Potential participants were recruited through networking with physicians and other health care providers at mental health care facilities in Central/Regional North Carolina. A researcher-participant relationship did not exist in this study. Identification of gatekeepers, people who would allow access to these settings and the population, to help the researcher establish a rapport with potential participants took place (Patton, 2002).

Gatekeepers who agreed to identify individuals who met the inclusion criteria provided potential participants with study information on how to contact the researcher if they are interested in participating in the study. When potential participants called the researcher, an explanation of the purpose of the study and the inclusion and exclusion criteria as well as the risk and benefits of participating were provided. Individuals who agreed to participate in the study and met the inclusion criteria were scheduled to meet with the researcher. Participants were compensated with US \$20 for participation in the study. Monetary incentives can be useful for increasing participation rates among individuals who are typically less likely to take part in research projects (Guy, Spoth, & Redmond, 2004; McFarlane, 2007).

### ***Setting***

This study was conducted in Central/Regional North Carolina. Participants who were interested in participating in the research study were asked where they wanted the interviews to take place. All twelve participants were residents of a transitional home for recovering substance abusers. Since a number of other residents were living in these homes, participants were asked to identify a place where confidentiality of the information could be maintained. Ten participants were interviewed in common areas in the residence where the door was closed for privacy. One participant asked to be interviewed in her room and one participant wanted to be interviewed on a screened in porch so there was a clear view of outside.

### ***Data Collection***

“We cannot observe how people have organized the world and the meanings that they attach to what goes on in the world. We have to ask people questions about those things. The purpose of qualitative interviewing, then, is to allow us to enter into the other person's perspective. Qualitative interviewing begins with the assumption that experience of others is meaningful, knowledgeable, and able to be made explicit” (Patton, 2002). An interview is the product of what interviewees and interviewers discuss together and how they talk with each other. The record of an interview that researchers make and then use in analysis and interpretation represents that discussion. Open-ended interviews provide participants the opportunity to describe their experience (Speziale & Carpenter, 2007). In this study, data was collected through in-depth interviews using the following open-ended question: “Please tell me what it is like living with bipolar disorder and comorbid substance use disorder. Share all your thoughts and feelings about the experience until you have no more to say.” To increase the quality of the interview, an interview guide with probe questions were used (see Appendix A). Participants were asked to provide examples that helped describe their experiences. This type of inquiry typifies the format generally used in phenomenological interviewing (Beck, 1992; Kennedy, 1995; Speziale & Carpenter; Zalon, 1997). This is an important advantage when conducting exploratory studies on a complex and potentially ambiguous phenomenon (Nieswiadomy, 2008).

The primary instrument in studies relying on in-depth interviews for data collection is the researcher. A tape recorder was used to record interviews so that verbatim transcripts could be obtained for data analysis. The researcher maintained and

collected field notes of responses, expressions, and emotions that may not be captured by audio tape. One audio-taped interview was conducted with each participant. After review of the audio tape and transcripts of the participants experiences, the researcher returned to the participants for a final telephone interview. A final telephone interview was conducted to validate the data heard during previous interview. This also gave the researcher time to review the previous interview for clarification prior to the next interview. Thus there were two interviews with each participant. The interviews lasted approximately 45 minutes to 1 hour.

### ***Data Analysis***

Data analysis and data collection occurred concurrently. Colaizzi's (1978) method of data interpretation was used as the framework for data analysis. The researcher spent time dwelling in the interview data until the essence and themes of patients with bipolar disorder and comorbid substance use disorder were identified. This included the researcher listening to the audio tapes several times listening for inflections in the participants voices and matching field notes with audio recordings. Dwelling with data involves complete immersion in the generated data and allows for full engagement in the analysis process (Speziale & Carpenter, 2007). To help the researcher set aside personal biases, bracketing was employed, allowing the researcher to cognitively put aside her own beliefs and not make judgments about what had been heard or observed (Speziale & Carpenter). The researcher's feelings and thoughts were written into a journal to assist with bracketing and the reflective process daily. Additionally the researcher used an audio tape recorder to record feelings and thoughts.

Colaizzi (1978) suggests that you should extract significant phrases and statements from transcripts that together form the whole meaning of the experience of bipolar disorder and comorbid substance use disorders. Extracting will be used to aggregate data so the researcher can work with it and gain a new perspective on the data (Speziale & Carpenter). Each transcript was analyzed to identify statements that tell the story of each participant's lived experience.

Formulated meanings that describe the phenomenon of the lived experience of bipolar patients with comorbid substance use disorder were identified. The researcher attempted to formulate more general restatements or meanings for each significant statement identified in the analysis. Analytical coding was done to identify attributes and formulate meanings. To assist in this process, the researcher used the concept of reflection. Reflection on the words of the participant is of particular importance in the phenomenological process. "The phenomenologist borrows the description of the participants experience and reflects on them" (Munhall, 1994, p. 304). The researcher is required to use a certain amount of intuition in the analysis of the participant's words and through noted observations of body language, tone and pitch of voice. Intuitive inquiry will position the participants' experiences at the center of the inquiry and stay as close to their voices as possible (Braud & Anderson, 1998).

Formulated meanings were organized into clusters of themes and then collapsed into emergent themes. The researcher returned to a member of the dissertation committee to examine the relationship between formulated meanings, theme clusters, and emergent themes to ensure that the interpretive process was described clearly and accurately.

Additionally, for the sake of clarity, the researcher included a discussion regarding interpretive decisions related to clusters and emergent themes. Colaizzi (1978) suggests that the final validation stage of data analysis should involve returning to the participants for another interview and eliciting views on the essential phenomenon to ensure that it represents their experience. Participants in a final telephone interview validated essential structures of the lived experience of adults with bipolar disorder and comorbid substance use disorder.

### **Validity and Reliability**

Research must be valid and reliable. The ability to describe and demonstrate an audit trail of decisions made during the data collection and analysis process and the researcher's role, thoughts, feelings, and reflections help promote the credibility of the study (Sanders, 2003). A variety of techniques were used to enhance the credibility and trustworthiness of the data in the study. These included descriptive and interpretive validity.

Descriptive validity and interpretive validity are two concepts developed by qualitative researchers to demonstrate the qualitative paradigm and solve the dilemma of measurement validity (Creswell & Miller, 2000; Maxwell, 1992). Descriptive validity is the foundation of which all other forms of validity are built. It refers to the accuracy of the data and its reflection of what the participant said (Creswell & Miller; Maxwell). Descriptive validity in this study was addressed by peer debriefing and leaving an audit trail.

Peer debriefing is the process of allowing a peer who is a professional outside the context and who has some general understanding of the study to analyze materials, test working hypotheses and emerging designs as well as listen to the researcher's ideas and concerns. Copies of the research report were provided to two members of the dissertation committee who are knowledgeable of qualitative methodology, interview techniques and bipolar disorder. This assured that data analysis and research techniques used were in accordance of those uses in qualitative methodology. The audit trail helps establish the credibility of qualitative studies and provides evidence that recorded raw data have gone through a process of analysis, reduction, and synthesis (Wolf, 2003). Transcribed interviews, field notes of observations and participation with informants, document analysis, literature analysis, and personal notes or the reflective journal of the investigator will remain available for audit. A member of the dissertation committee reviewed these materials regularly.

Interpretive validity captures how well the researcher reports the participants' meaning of events, objects and/or behaviors (Maxwell). In this study, interpretations were based on the participants' perspectives. After analyzing the interview data, copies of significant themes were made and handed to the participants, who were asked to evaluate the findings. Six of the participants were available to evaluate the findings. The participants had the opportunity to add or make changes. This process is called member checking, which involves confirming findings with the participant (Speziale & Carpenter, 2007). The ultimate test of the quality of the phenomenology would be testimony from the participants themselves that the researchers' universal description of the phenomenon

captured their personal experience (Wojnar & Swanson, 2007). Participants believed their experiences had been captured.

### **Human Subjects Consideration**

This research proposal was submitted to the Human Subjects Committee of the University of North Carolina at Greensboro. Letters of support and other approval associated with the recruiting from mental health facilities was obtained. Informed consent from prospective participants was obtained both verbally and in writing. Written consent forms included permission to audio tape record the interview, and also explained the procedure by which the informants' confidentiality would be assured (Appendix B). Written consent forms were obtained during the initial contact with prospective participants. Participants were reminded verbally, during each interview session, that they may elect to have the audio tape recorder turned off or have the interview stopped at any time. When the participants appeared to be getting emotional they were asked if they wanted to stop the interview process. Participants were asked to provide the researcher with an address and telephone number so that transcripts could be validated.

Client confidentiality was assured by coding participant responses. Participants were also given pseudonyms. The researcher and the dissertation chair are the only persons who have a record of the names of the participants. This information is currently being kept in a locked file-box in a secure office. At the completion of the study audio-tapes and transcripts will be destroyed.

The author was the sole researcher for this study, and with a number of diverse experiences that have contributed to the development of her communication and

assessment skills. These experiences include: a pilot study involving the interview process; employment in several psychiatric settings and the mental health arena as a nurse, didactic and clinical instructor; and twenty years of work experience as a registered nurse. This allowed the researcher to assess whether participants were cognitively able to consent to participate in this research. The researcher could also determine if participants were becoming compromised during the interview and refer them to other forms of healthcare support this was not needed. No major risks are anticipated for this study.

## **CHAPTER IV**

### **FINDINGS**

This chapter describes the sample and findings of the study. Findings are presented in accordance with Colazzi's (1978) phenomenologic methodology and include extracted significant statements that pertain to the phenomenon, their formulated meanings, themes that were common to all participants and an exhaustive description of the experience of being an adult living with bipolar disorder and comorbid substance use disorder. All words in quotation marks are taken directly from the participants' transcripts of the interviews.

#### **Sample Characteristics**

The sample consisted of twelve participants, one male and eleven females, who lived in the Southeastern region of North Carolina. Upon initially contacting the researcher, participants who volunteered to participate in the study were asked to verbalize they met the study criteria. The participants were also identified as being patients at a local psychiatry specialty clinic, which was the approved site for participant recruitment. In addition to recovering from a substance use disorder, all of the participants were being treated for bipolar disorder. Participants' eligibility for the study was verified verbally before the interview process begun. Specifically, all of the participants stated they were over the age of 18, were being treated by a referring physician and had been diagnosed with bipolar disorder and a comorbid substance use

disorder. The participants were all residing in a residential recovery facility with other individuals who were recovering from substance use disorders. To ensure confidentiality, participants were assigned a unique identifier number and then given a pseudonym. There were seven African Americans, four Caucasians and one Asian American. Their ages ranged from 33 to 52 years. None of the participants were using substances and they stated they were sober. At the time of the interviews participants all had negative results on random drugs screens, which was a condition of their placement in the recovery facility. The participants also stated they were in the stable phase of bipolar disorder. The participants all celebrated their sobriety from drugs and alcohol, which ranged from nine days to three years. No matter how long they had been sober, all took pride in their sobriety. The researcher expressed genuine pride in their sobriety; and believed this was a method of forming a connection with the participants. All of the participants were friendly and, within minutes after the interview began, opened up and shared their stories. Of particular importance is that the participants stated previous participation in research studies, however, this was the first time all the participants had participated in face-to-face interviews in which they were able to tell the story as they saw it, of their experiences living with bipolar disorder and comorbid substance use disorder. A summary of demographic data appears below in Table 2.

### **Vignettes**

Brief vignettes about the participants are included to provide a short descriptive sketch of who the participants were. The vignettes give a glimpse of the participants as the researcher had come to know them.

**Table 2*****Participant Demographics***

<b>Participant Number</b>	<b>Pseudonym</b>	<b>Sex</b>	<b>Ethnic Background</b>	<b>Age</b>	<b>Drug of Choice</b>
0001	Charles	Male	Black	33	Crack Cocaine
0002	Mary	Female	Black	52	Crack Cocaine, Marijuana, Alcohol
0003	Amy	Female	White	38	Crack Cocaine
0004	Peggy	Female	Black	38	Cocaine
0005	Donna	Female	Asian	42	Crack Cocaine
0006	JoAnna	Female	Black	45	Alcohol
0007	Lisa	Female	White	33	Opiates Marijuana
0008	Gail	Female	Black	48	Crack Cocaine, Alcohol
0009	Carolyn	Female	Black	45	Alcohol
0010	Deb	Female	White	49	Alcohol
0011	Shirley	Female	White	41	Crack Cocaine
0012	Kathleen	Female	Black	38	Crack Cocaine

***Charles***

Charles is a 33-year-old, well-mannered and neatly dressed male. He has been sober for the past five months. He was diagnosed with bipolar disorder one year ago and had been using crack for the past four years. He described living with bipolar disorder and substance use disorder as complicated. His description of his illnesses was consistent with the classic signs and symptoms of bipolar disorder. “Sometimes I find myself very outgoing, very optimistic and other times I find myself very depressed and the opposite.” In the past, self-medicating with crack cocaine helped him manage his mood swings,

especially the lows. “It helped me hide my feelings and cover up any type of responsibility or emotions I had.” He has been in the recovery house for the past two months. Although this is not the first time he has been in recovery, he finds motivation in two sources. “My son is my inspiration.” Charles was working two part-time jobs and credits God in his life for helping him “stay positive.” His bipolar disorder is managed with medication, and he has come to a realization that he has to battle his substance use. “I have come to an acceptance of where I am in my life and I am working on a way to try and change me.”

### ***Mary***

Mary is a 52-year-old female dually diagnosed during her teenage years. She was 15 years old when she was diagnosed with a substance use problem and 17 when she was diagnosed with bipolar disorder. She has been sober for three years. She describes living with bipolar disorder as “scary but I have come to some acceptance. I accept that I have bipolar disorder and a substance use problem and I deal with it on a daily basis.” She also expresses living with mood swings. “My mood swings goes up and goes down, it’s confusing to me because I don’t know what causes it or what makes me the way I am today.” Her reasons for abusing drugs were “loneliness, wanting to feel loved; I’ve been through a lot of pain. Being high I didn’t have to think about the pain.” When she was actively using drugs, her drug of choice was crack cocaine. “Crack cocaine made me not have to feel and think.” She has been in this transitional home for three years. Mary describes the recovery process as “very hard” and an important part of being happy “because today I know I don’t got to use no drugs.” When asked what motivates her, she

states “Life itself, the sky, waking up in the morning, being clean and people wanting to understand a lot about my disease.” Mary is deeply anchored in her faith in God. “God loves me, my life is based on what I know God has for me, not what I have for myself.”

### *Amy*

Amy is a 38-year-old female who is very pleasant and energetic. Her smile, upbeat tempo and warmth communicated her positive outlook on life. She comments that she “feels good despite what she has been through.” She has been abusing drugs since she was 17 and says “I’ve been running a race with crack cocaine for fifteen years.” It has been just one year since she was diagnosed with bipolar disorder. Initially, Amy felt helpless. “I found out there was hope for me and I’ve been clean for five months.” Amy described mood swings associated with her bipolar disorder: “Everything can be going good; I’d have real, real highs and then all of a sudden I just get depressed.” Amy noticed her change in mood a few years ago; however, she states, “I just medicated, self-medicate it, you know. I would use drugs. They would make me feel normal.” Amy has been in recovery and on her medications for five months. “My recovery is the best thing that ever happened to me, it gave me a foundation.” While Amy works diligently trying to maintain her sobriety and manage her bipolar disorder, she feels that “managing the substance use problem is a bigger issue right now.” She believes if she stays off drugs and on her medications that she can be “pretty mellow.” A motivator for her is “being around positive people.” Amy identifies healthy as “being connected” and “making right choices.” She accepts that she “has some issues” but right now all she can see is that “there is hope, there is hope and it is appreciated.”

***Peggy***

Peggy is a 38-year-old female who has been dealing with bipolar disorder and comorbid substance use disorder for the past 14 years. At age 25 she was diagnosed with a substance use disorder and two years later she was diagnosed with bipolar disorder. She has been sober and in recovery this time for 60 days. Her recollection of the issues in her life surrounding her illnesses is good and her descriptions were vivid. She described a manic episode as “a cup of coffee that never wears off.” Peggy described a typical day trying to manage her bipolar disorder and substance use as “crazy.” “You can go out and get high and do whatever you want to do, but the bipolar is still there and you can’t manage it meds or not.” She mixed prescription drugs and recreational drugs. “I would take my medication for my depression and cocaine to get me all pumped up.” She is not new to recovery. She has been in recovery several times before and feels like she is “well-known” by staff from her frequent visits. Peggy is motivated by her desire to live, “If I want to live there are things I just have to do.” She also believes that God helps her cope with life. Peggy is currently compliant with her medications and substance use treatment. She knows “the medication is just to help, it’s not to cure.” Before the interview concluded Peggy shared with the researcher that at the present time, “I’m living with them (bipolar disorder and substance abuse) the best way I can.”

***Donna***

Donna is a quiet, shy 42-year-old mother of four. She has been battling substance use for 22 years and remembers being told 16 years ago that she had bipolar disorder. She has been sober and in recovery for 60 days. She described living with both bipolar

disorder and a substance use disorder as “complicated at times.” When asked to expound she states, “Being on the medications, being in this treatment house, I have some issues.” Donna had negative thoughts about what bipolar disorder meant, so the mention of it by her doctor made her think she was “crazy.” She has mood swings regularly and talked about how she “splurges a lot.” Her drug of choice was crack cocaine, which she used to “pep her up” and help her with “the emotional side of things.” “It was making me feel good at one point until it got to the point where I didn’t feel anything.” She has tried recovery before and, despite the four other programs she has been in, she “still got out and used.” Donna says that, “God and my kids are my motivation” and feels that despite all she has put them through she has a “bond” with her four children. She had to come to terms with her life, get off the streets, go to the doctor, take her medications and do whatever she had to do or she “was going to die.” Now, Donna says she is “dealing with her diseases on a different level” and doing whatever it takes to live.

### ***Joanna***

Twenty-six of Joanna’s 45 years have been spent dealing with alcohol and mental illness. She was diagnosed with schizoaffective disorder over 20 years ago but rediagnosed with bipolar disorder five years ago. Joanna is very proud that she has been sober for 45 days. The feelings of being “manic-depressive” have been with Joanna since she was 12 years old, which was when she was victimized sexually. She has some periods of euphoria “when everything is good and she does not have a care in the world.” However, she experiences more periods of depression and that is where the alcohol, her substance of choice, entered. “I really became dependent on it on a daily basis. I was a

chronic alcoholic. I woke up drinking, I went to bed drinking.” The structure in the recovery house is what she finds the most helpful. She hopes to remain sober this time. Prior to this period, she had remained sober for two and a half years and recently relapsed when she lost her apartment after being denied disability. God and a better relationship with her children are the motivating factors for staying focused on stabilizing her illnesses. Joanna believes that if she could manage her bipolar disorder, the substance use would fade away: “I would be on my medication and better able to handle a crisis in my life.” Joanna is trying to learn to “deal with life on life’s terms.” She dreams to function in society, “I would like to see that I’m needed somewhere.”

### *Lisa*

Lisa is a quiet and shy 33-year-old mother of one. She was a little sluggish, but the participant felt this was probably due to the doctor trying to regulate her medications and it took an effort for her to focus her thoughts. She had been in a six-month recovery program prior to admission to the treatment program where she is now. Less than one month prior to her release from treatment, she relapsed. Lisa stated “I couldn’t handle the pressure,” and “I didn’t know what I was going to do afterwards.” This had occurred only nine days before the interview took place. She held her head down as if she was ashamed because “five months is the longest period of sobriety” she has ever had. Lisa was diagnosed with bipolar disorder at the age of 27, prior to being diagnosed with a substance use disorder. She was treated with opiates for physical illnesses and “got hooked on pills and was abusing them.” She self-medicated and used them to help her deal with several traumatic experiences that occurred in her life. She describes having a

substance use problem with bipolar disorder as “even worse.” This is because she experiences “racing thoughts and not feeling good” from mood swings; there is also the added cravings and battle with addiction. Lisa is trying to refocus on her recovery and was placed back in the recovery house three days ago. Her relationship with God keeps her motivated and strong, “and of course my daughter; my mom won’t give her back until I am on my feet and right.” When asked how she felt about herself now Lisa stated, “I’m okay, trying to see that there’s a light at the end of the tunnel.”

### ***Gail***

Gail is a 48-year-old female who has been dealing with a substance use problem for a long period of time. “It has been a constant thing for the past 26 years until I came here.” She has been sober for the past 30 days. Her bipolar disorder was not diagnosed until eight years ago but she says, from her understanding of the disease, she probably had bipolar disorder before the diagnosis but she was unaware of it. When asked to describe her experience living with bipolar disorder and substance use disorder, she says, “Oh God, boy; I’m just happy and in control of things, other times I cry and don’t know why or I am always anxious like something bad is going to happen.” To deal with this she used crack cocaine and alcohol: “They made me peaceful and happier.” She doesn’t speak much about her recovery other than to share that she goes to meetings and to see her therapist regularly as a part of the recovery process in this house. Gail is motivated by “a need to change.” She wants to be healthy. Getting her mental health right will help her with her physical health issues and, even though she won’t be cured of her problems, “I can deal with it better.”

***Carolyn***

Carolyn is a 45-year-old widow with 10 children. She jokingly says “that’s enough to make you be bipolar, isn’t it?” Living on the streets has aged her and she had her front teeth knocked out in a fight. She has been sober and free of alcohol use for 90 days. She was diagnosed with bipolar disorder at age 27 and a substance use problem at age 30. Her mood swings were a constant thing without medication and she had “no rest except when drinking and drugging.” Carolyn described periods of racing thoughts, rage and anger alternating with periods of deep depression. If she was depressed, there were no feelings of happiness unless she was using. She believes that being in recovery and on her medication makes her life better: “It’s a whole new life.” God and her twin daughters are Carolyn’s basic supporters and motivators. Presently, she is managing her diseases through recovery and medication. She states she is in compliance with her treatment regimens. She believes that she has to take care of her problems because “if you don’t they get worse and worse and you continue to go downhill.” She is holding on to hope that as long as she tries “it will get better and better.”

***Deb***

Deb is 49 years old, but 24 years of alcohol use has aged her. It was apparent that she had some residual effects from years of alcohol use. She spoke slow, had to focus on her words and had a mild tremor. Deb has not had alcohol for the past 90 days. She was diagnosed with bipolar disorder just six years ago but jokes “my pastor told me I was a nut before that.” For Deb living with bipolar disorder and comorbid substance use seems like all she knows. “I take different medicines. Um, when I’m up I’m happy, but when

I'm down I mean I'm down. So I get high. I mean it seems like that is all I know." The bipolar disorder and substance use make her "irrational." "Once I purchased two PT Cruisers in two days." She has been in and out of mental hospitals and recovery houses for years. She has had things stolen from her, which is why she carries her most valuable possessions in a large tote bag with her. She believes God has kept her alive for a reason because she should have been dead a long time ago. Deb believes the "grace of God" keeps her motivated to stay sober. Deb wants to be able to help people. She was raised to be of service to others and it is important to her to be able to do this but at this point, she believes she is in no condition. "I've got to get myself into shape before I can help anybody else."

### ***Shirley***

Shirley is a 41-year-old mother of two. Shirley has been diagnosed with a substance use problem for twenty years and bipolar disorder for five years, but she says she believes "I've probably been bipolar all along." She has a new granddaughter and at this point in her life she is "tired of being sick and wants her family to be a family again." She openly talked about her bipolar disorder and joked about first being diagnosed. "I told them I wasn't bipolar. I told them I was a Gemini and my husband knows which one is which." Her comment was a joke but she had lived going from being "happy, happy" to "sad and withdrawn." Shirley describes her recovery process: "I had been three months clean, had a small little episode, was six months clean, and I'm now working on 30 days." She was proud of her sobriety and her ability to resist the temptation of using crack cocaine. She believes her priority in life is staying healthy and on her medications,

because when she is not she “uses more” to deal with the mood swings. Her conversation centered on reconnecting with her teenage daughter. “I’m still beating myself up about losing my daughter.” Shirley’s motivation was getting her daughter back, “I want to get my daughter back and be a better mother than I was.” She met her husband when she was fourteen and they are working on renewing their relationship. Shirley feels hopeful that this time she can stay on her medications and remain sober.

### ***Kathleen***

When 41-year-old Kathleen was asked what it is like living with bipolar disorder and comorbid substance use disorder, she began to cry, her facial expression revealing that she was struggling with trying to live with being dually diagnosed. “I wasn’t gonna cry today, every time I talk about this I cry.” This was her response to dealing with “extreme highs and lows” and “battling” substance use at the same time. She recalled the turmoil that has filled her life since she was a teenager. She had been using crack cocaine since she was 19 years old and was diagnosed with bipolar disorder at the age of 35. She has been sober and in this recovery house for 120 days. “This house keeps me very vigilante,” says Kathleen of the place where she has now been for four months. The words of her three teenage boys’ motivate her “No matter what we love you - you’re still mommy.” Her bipolar disorder and substance use has resulted in her losing custody of her children. She is close to being released from the recovery house and voices some concern about leaving the structured environment. When asked why she is concerned, Kathleen describes her bipolar disorder as “powerful.” However, she believes that if she manages her substance use, she will also be able to manage her bipolar disorder.

## Study Findings

Colaizzi's (1978) descriptive, phenomenological method was chosen to guide the inquiry in both interviewing the participants and in analyzing. This involved the seven-step procedure outlined in the methods section. First, each of the participants' audio-taped interviews were listened to and transcribed into a written text by a trained transcriptionist. This was followed by listening to the audio-taped interviews again while reading the transcripts to assure accuracy. Significant participant statements and phrases pertaining to the lived experience of being an adult with bipolar disorder and a comorbid substance use disorder were first underlined and then extracted from each transcript. For each of the participant's significant statements, meanings were formulated to reflect each statement and phrase. The significant statements were again reviewed to ensure that the formulated meaning truly reflected the intent of the statement. The formulated meanings were organized into eleven broad categories and from these broad categories into clusters of themes. A table was created of each participant's significant statements, formulated meanings and categories. A sample page of this is shown in Appendix C. The themes were reviewed and compared to the meanings statements again, to ensure that they reflected all of the content described. The results of the data analysis were integrated into an exhaustive description of the phenomenon. In order to achieve validation of the meaning of the data, the exhaustive descriptions were shared with participants. The researcher made phone calls to all of the participants to achieve final classification of the meaning of the data. Only six of the twelve participants were accessible by the contact information provided to the researcher. Descriptions were read to these participants, who

were asked to indicate whether they agreed or disagreed with the exhaustive description. The participants all agreed with the exhaustive descriptions and were excited to “have a voice” and “be understood.” “I appreciate you getting my side of the story,” exclaimed one participant.

### ***Significant Statements***

Once significant statements were identified using line-by-line analysis, they were extracted from the transcript and placed in the researcher-designed table for further analysis. Statements were placed into twelve broad categories. Some statements were placed in more than one category. The categories with examples of a significant participant statement are as follows:

#### Drug Use and Addiction

1. I winded up smoking crack and the last four years of my life, it has been crack.
2. I have been running the race with crack cocaine for fifteen years.

#### Signs and Symptoms of Bipolar Disorder

1. I get manic. I'll be flying around here cleaning up.
2. I have irrational thoughts and I splurge.

#### Knowledge of the Disease

1. I had never heard of bipolar disorder before.
2. I still don't really understand what it (bipolar disorder) is.

#### Facing Challenges

1. I am just tired of living with disease.

2. It's hard for me to balance the two.

#### Traumatic Experiences

1. I grew up in a very violent home.
2. I was raped by the bus driver.

#### Self-Medicating

1. I would stay high so I didn't have to feel.
2. I tried to use drugs to help pep me up.

#### Wanting to be Healthy

1. There are ways to get well.
2. I am taking my medication to help me.

#### Trying to Recover

1. I'm in a structure right there limits me getting to alcohol and drugs.
2. I'm managing with medicine, meetings, talking to my sponsor.

#### Living With the Stigma

1. When they first diagnosed me I associated it with being crazy.
2. We're not crazy people.

#### Motivation

1. My daughter motivates me.
2. I pray for God's help.

#### Relationships

1. I lost my daughter.
2. I was not close to my mother.

### *Formulated Meanings*

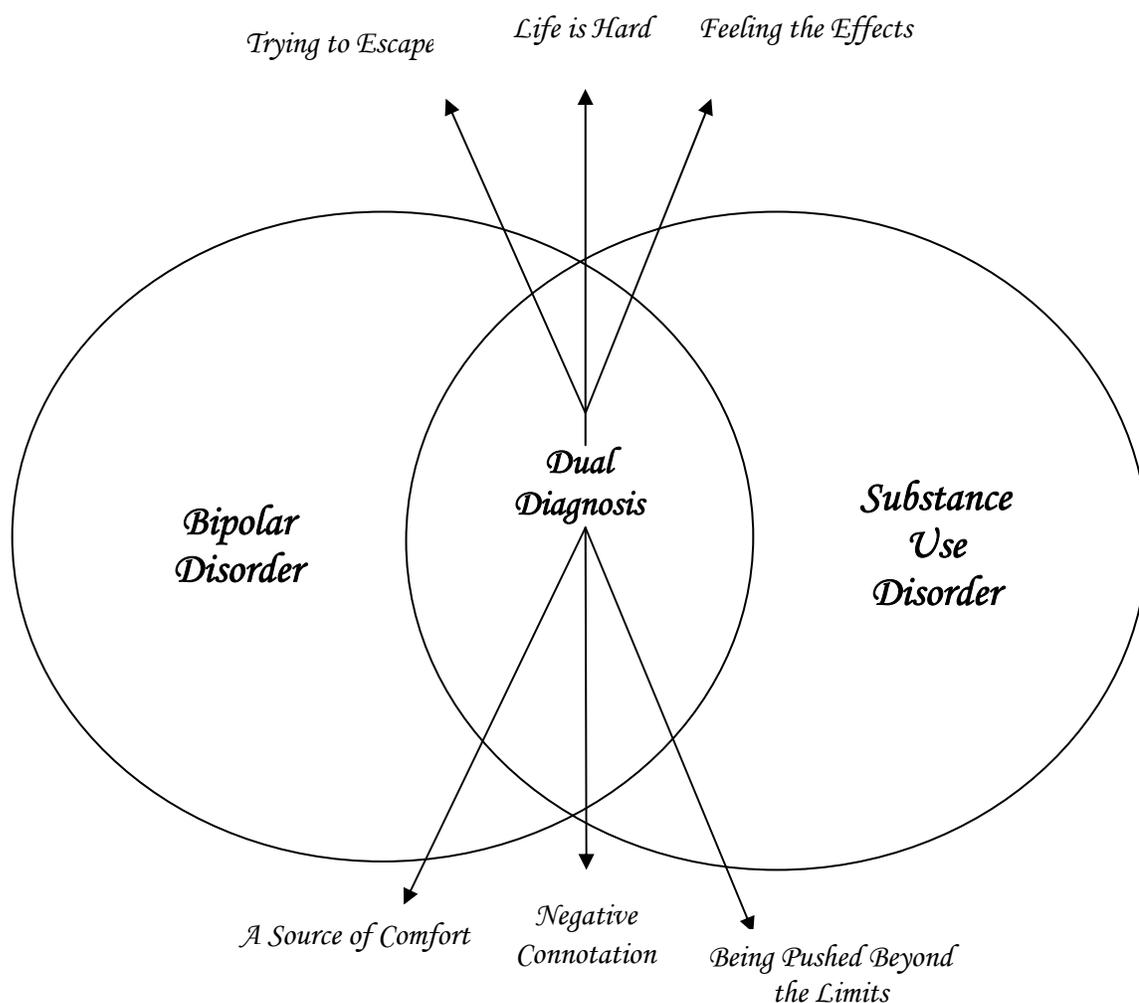
For each significant statement, a brief description of the underlying meaning was devised. Formulated meanings were intended to answer the question, “What is the substance of what the participants are saying?” The formulated meanings typically were edited or truncated versions of what the participants had said, using the original language as much as possible. The process of creating meanings was done by the researcher and discussed with an experienced phenomenologic researcher who is a member of the dissertation committee. Through this process the formulated meanings were validated. The following are examples of significant statements with their formulated meanings:

<u>Significant Statements</u>	<u>Formulated Meanings</u>
1. I'm just happy and I'm in control of things.	I experience mood swings and other times I just cry.
2. I tried to kill myself three times.	I was suicidal.
3. People are afraid of you or make fun of you.	I feel stigmatized.
4. I use crack cocaine and alcohol but I have tried it all.	I have used drugs.
5. I was out there to use, it made me feel better.	I have self-medicated.
6. They took my daughter from me and placed her with my grandmother because I was ill.	There are consequences of my diseases.
7. To this day, it is hard and frightening.	I face challenges living with my diseases.

### *Themes*

The subtleties and complexities that defined the experiences of the participants emerged from the formulated meanings. Formulated meanings were organized into six theme clusters describing the lived experience of adults with bipolar disorder and comorbid substance use disorder. The six themes that emerged from analysis of formulated meanings were: (1) It is hard; (2) Feeling the effects; (3) Trying to escape; (4) Spiritual support; (5) Being pushed beyond the limits; and (6) A negative connotation. All six themes emerged from a phenomenologic analysis of all participants' stories. No one theme was dominant but all the themes came from the interconnection of bipolar disorder and substance use disorder, or being dually diagnosed. The thematic structure is diagrammed in Figure 1.

***“Life is hard.”*** For the participants in this study, it was hard living with bipolar disorder and comorbid substance use disorder because they faced a numerous challenges. The first of these issues was trying to manage bipolar disorder, comorbid substance use disorder and the day-to-day reality and emotional instability in their lives. They were plagued with signs and symptoms of two major mental illnesses as well as a number of other health issues. Trying to socialize and get people to understand or relate to their problems were also major problems, putting successful relationships on the outer boundaries of their reach. Finally, their diseases were interconnected, which meant one always affected the other despite their attempts to manage them according to treatment protocols.



**Figure 1. Thematic Structure: The Lived Experience of Adult Patients with Bipolar Disorder and Comorbid Substance Use Disorder**

It was like a pendulum—they were either dealing with bipolar disorder or substance use disorder; it never stopped. Trying to manage the challenges they faced in life overpowered them no matter how hard they tried to conquer them. Charles was working everyday trying to be a responsible father and trying to manage his substance use and bipolar disorder. Living with his problems often took a toll on him:

Sometimes my problems and situations overwhelm me, I like just basically am, not being able to take life, accept life on life's terms and deal with life. I just don't want to deal with people or the reality of it all. (Charles)

Participants described problems dealing with the emotions of anger, fear, anxiety, depression and emptiness. The uncontrollable swings in mood were difficult to manage making life more:

It is hard living with it, mood swings, depression, anxiety, real terrible anxiety. Living with life on life's terms, I live most of my life in fear; it is hard. (Gail).

Their lives were hard because they were trying to manage bipolar disorder and substance use disorder along with other health issues. There were participants with physical illness including HIV, back injuries, pancreatitis and liver dysfunction as well as other mental illnesses such as posttraumatic stress disorder and personality disorder. Life was not hard just because they were dually diagnosed; living with these diseases was hard because multiple health issues affected them. Participants had two major mental illnesses in addition to other medical issues and they were trying to manage them all:

I live with bipolar disorder. I live with drug addiction and I live with HIV. So, I have a lot of things that I deal with on a daily basis. I thank God I didn't go crazy. (Carolyn)

Life was hard because they had problems socializing. Bipolar disorder and comorbid substance use disorder was described as sometimes being severe enough to cause marked impairment in social interactions. Participants were either in a deep depression and withdrawn, or in frenzy and out of control from their bipolar disorder:

I could not figure out exactly what to do with others or myself. I was always just very frightened, even to this day it is hard and frightening. It is hard to socialize normally. (Joanna)

Participants' drug-seeking behaviors caused them to crave drugs and go to any lengths to get them. They would lie, steal and manipulate people they were close to and those who loved them. This resulted in damaged relationships and social structures. For the participants making amends in these relationships, things were easier said than done:

It is hard to get people to want to be around you, to trust you after all you put them through. (Amy)

The experience of being dually diagnosed was hard because people did not understand their situation. Participants spoke of people not being able to relate to the problems they faced on a daily basis. They felt the effects of bipolar disorder and comorbid substance use disorder on their lives as a whole was not understood. They did not feel as if people understood that having bipolar disorder and comorbid substance use disorder meant they were sick. There were challenges they faced in treatment for bipolar disorder and recovery for substance use. Participants felt that the challenges of disease management and recovery were not understood:

Some people just don't understand it's hard. I want them to understand it's hard. Some people say they understand. I know they did a lot of studies but they don't really understand it's hard trying to stay clean and trying to stay on your meds. (Kathleen)

People don't know what I have been through and they don't understand that we are sick, we're just sick. (Carolyn)

Because bipolar disorder and substance use disorder are interconnected, life for the participants was hard. The problems of having bipolar disorder and a substance use disorder were so closely interrelated for participants. Sometimes their mood stabilizers did not work, so they used substances that in turn, intensified the symptoms of their bipolar disorder. This resulted in participants being more irrational and less inhibited. They described it as a vicious cycle. Life was hard because the participants described “not knowing where the bipolar ended and drug use begins:”

It is hard, I think it's even worse having a substance use problem, because you are already dealing with the racing thoughts and not feeling good all the time, you know, you're up and down especially if you are not on your medicines. Um, having the substance use problem really adds to it, to me. It makes me crave more even though I'm on my bipolar meds. (Lisa)

The lives of adults with bipolar disorder and comorbid substance use disorder can be described as difficult and arduous. They found life overwhelming and the complex issues associated with bipolar disorder and a comorbid substance use disorder were extremely challenging. “Life is hard,” meant that participants began everyday knowing they were going to be challenged in some area of life. Participants described knowing they were going to have to address issues associated with their bipolar disorder and comorbid substance use disorder. Their disorder made the normal everyday life stressors more challenging. Living with bipolar disorder and comorbid substance use disorder complicated their physical health, emotional health and relationships.

***Feeling the effects.*** Each participant talked about how living with bipolar disorder and comorbid substance use disorder affected all aspects of their life. They spoke of the

effects of their mental illnesses on their social status, economic status and relationships with their children and loved ones. They described how losing material possessions, using drugs and suffering from bipolar disorder made them reckless. They spoke of how trying to use drugs to treat signs and symptoms of bipolar disorder had made them do things they were “ashamed” of such as being charged with and committing criminal offense. There were consequences of their mental illnesses, which affected the people they now are.

The participants engaged in a number of risky behaviors. Their lack of inhibition was bought on by both their bipolar disorder and substance use disorder. They had patterns of putting themselves in the way of harm. This included driving under the influence of alcohol and drugs, risking not only their lives but also the lives of others:

My worst experience of being manic was probably driving high with my daughter in the car, nodding at the wheel. I remember one day in particular I fell asleep at the wheel and my brother was with me luckily and he made me pull over and he drove. (Lisa)

Participants also got involved with people who were dangerous and often times they were involved with people they did not even know. They did not value their safety and this was a risky behavior. They were glad that this behavior had not resulted in them being killed:

I would pass out, and when I came to somebody’s screwing me and I don’t even remember who they were. I don’t have any clue. Wake up and God knows who, could have a murderer beside you. (Carolyn)

The participants reported being involved in sexually risky behaviors, including unprotected intercourse, multiple partners, sex with prostitutes (for the male participant), and sex trading:

I have a habit, women. The whole start of my bipolar and substance use was because of loneliness, you know. I needed some companionship and I was looking in the wrong places and eventually tied up with the wrong people [prostitutes]. This is how I picked up drugs. (Charles)

Meade, Graff, Griffe, and Weiss (2008) suggest that patients with bipolar disorder and substance use disorder are at high risk for HIV infection. The participants reported feeling as if they had put themselves at risk for being infected with HIV. Indeed, three of the twelve participants were infected with HIV and believed it was related to their sexually risky behavior of prostitution:

I sold my body, I think HIV is a result of that; I didn't put it (drugs) in my veins. So yeah, unprotected sex is how I got it. (Donna)

Participants had taken risks and jeopardized their personal safety as well as endangered the lives of others. Most participants had been fortunate and their risk-taking behaviors did not have permanent consequences. However, three of the participants in would spend the rest of their lives trying to manage one effect of their risk-taking behavior: HIV.

Participants in this study believed that their bipolar disorder and substance use disorder led to their criminal activity. They were arrested for criminal offenses such as drug possession, possession of drug paraphernalia, driving under the influence,

performing sex acts in public, prostitution, burglary and forgery. All of the participants had committed at least one crime and had a criminal record as a result:

I got a drug charge and I got put in jail as a part of a plea bargain. I was in jail for two months for forgery. I stole from my mother, prostituted, writing checks, stealing other people's checks and credit cards. Just about any and everything short of hurting somebody physically. (Amy)

A criminal record was described as having a long-term affect on participants.

They were paying the consequences for their criminal actions. For the participants whose illegal activity had resulted in a criminal record, the major effect was poor employment outcomes. Social stigma was another effect associated with having a criminal record. This was in addition to the stigma associated with being diagnosed with bipolar disorder and substance use disorder:

I've created for myself getting into drugs a criminal record. This criminal record has been hindering me. I was a very prominent engineer at IBM for a year or two. Having this record and being looked at as a criminal because when they see my record they think that I'm just a barbaric animal criminal and having a four-year college degree it's not appreciated. I've been dealing with this for two years and still haven't broken ground professionally getting back into my field professionally in two years in recovery. (Charles)

Involvement in criminal or illegal activity resulted in participants feeling the effects of criminalization. They wanted to be free of this consequence of their disease. However, in the society and communities in which they resided, their criminal records were permanently affected and they had to live with them.

The effect of torn relationships with their families and loved ones was the most difficult one for them to accept because they had damaged and ruined these relationships.

Ten participants had lost custody of their children. This was the most devastating consequence of living with bipolar disorder and substance use disorder:

I would holler, curse, rant, and rave. Me and my daughter we would get into it. She would say mama you're a bitch. We'd fought with each other a few times. I lost my daughter. But, I'm gonna get her back. I'm still beating myself up about that. My son, I have a 24-year-old boy and he like, he just wouldn't have anything to do with me. (Shirley)

Participants had lost the respect of their children and, in most cases they had lost connections with their children because of their illnesses. They were not willing to quietly accept this consequence. Trying to win their children back was difficult.

Participants wanted to have a relationship with their children and they worked towards it:

I had lost my children when they were very young. When I was diagnosed, I was homeless and drinking real bad. But I found an apartment got back on my feet and got sick again. I lost connection with my children again. I'm struggling now to find connection with them. It's a struggle. (Joanna)

Outside of their children, they also had lost relationships with their dearest loved ones.

This included their spouses, mothers, fathers, brothers and sisters, aunts and uncles.

Relationships with their loved ones had been damaged and sometimes it was too late to repair them:

My mother was in the hospital and I was so high on crack, you know, I did not make it to the hospital but I could have been there a lot more and it just seemed like my whole life went to hell in a hand basket when my mother passed. (Peggy)

Another effect or consequence of being diagnosed with bipolar disorder and comorbid substance use disorder was the loss of material possessions. Participants lost or

traded material possessions for drugs or they left their possession behind while they sought drugs. They spent a lot of money on drugs and did not have money for much else. Amy used her hands to motion as if to empty them or throw something away. This was her way of indicating the losses she experienced because of her mental illnesses:

I was in a wreck and I got a whole bunch of money. I bought me a trailer and some land and I lost it. All in one year, I lost my fiancé; I lost the trailer. It (drugs) took everything I had from me. It took marriage, it took cars, it took it all. (Amy)

The bipolar disorder made some participants splurge and go on spending sprees causing them to be reckless with their material possessions, particularly money. This kind of behavior was described by participants as occurring when they were under the influence of drugs and in the manic phase of their bipolar disorder:

When I am on a high, just happy go lucky, nothing seems to bother me. I splurge. I splurge a lot. I splurge on other people, not myself. I just splurge on other people, you know, buying this and that for them. (Donna)

While they were able to reflect on it during the interviews, it was obvious that they did not focus on it too much because, as Amy put it, “I can get things back.”

Lack of financial stability was an effect or consequence of being an adult with bipolar disorder and comorbid substance use disorder for these participants. The participants in this study could feel the financial impact of their disorders. Reasons for lack of financial stability included overspending habits, inability to keep a job, inability to qualify for disability and re-entry into the work force at or below minimum wage. All

of these issues were brought on because they suffered with both bipolar disorder and comorbid substance use disorder.

Participants discussed overspending habits for drug binges and shopping sprees. One participant in particular described spending as “splurging” and “being out of control”:

I would do irrational things. Go on shopping sprees. I bought two PT Cruisers in two days. I would just shop and I mean I shopped. (Deb)

Losing a job because of the manifestations of bipolar disorder and comorbid substance use disorder also led to financial issues. Participants spoke of the lack of judgment, which was associated with their drugs use, as being a barrier to keeping a job. This resulted in drug use while working and subsequent failure of drug screens. Additionally, they described their mood swings as the primary manifestation of bipolar disorder that kept them from working:

I would work for a while and then I'd quit. Just would stop going and it wasn't the job, it wasn't the people, it's just I would stop going. I didn't understand. I would be, I mean, up about the job, going in ready to do my job, and then, you know, shortly after I got the job I would, you know, they couldn't depend on me, all of the sudden, you know things changed. (Lisa)

Participants described not being able to qualify for disability as a reason for lack of financial stability. They spoke of failed attempts to get financial assistance because their illnesses did not manifest as physical limitations. They did not believe they could work but support agencies saw them as physically able with little consideration for their mental ability:

I lost my apartment. An organization called Darwin Housing Coalition. They was paying my rent until I could get my disability 'cause I filed for disability and I was denied. When I was denied my disability, they quit paying my rent, because they were saying, I guess they feel that I am able to work, which really I'm not ready for work. (Joanna)

Another reason for lack of financial stability identified by participants was the inability to re-enter the workforce with the earning potential they had prior to being displaced from it. This was the effect of being diagnosed with bipolar disorder and comorbid substance use disorder. Participants described becoming stable in their illness and having to take jobs below the financial level they were accustomed to before becoming ill:

Because I started to use drugs and the being bipolar, I have to take any job I can. My three-year-old he lives in a situation, he's living, uh, at a level; he's living at a level of poverty because of his father. To see my child living in the ghetto, so to speak, and myself shortly below that. (Charles)

Participants described not possessing a feeling of financial stability. They clearly identified this as an effect of bipolar disorder and substance use disorder. They hoped that one day they would be able to stand on their own financially and wanted to be able to "take care of their needs" but at the time this study was conducted none of them were close to this goal.

The effects of their disorders were risky behaviors, criminal offenses, torn relationships, loss of material possessions and lack of financial stability. The lived experience of having bipolar disorder and a comorbid substance use disorder meant feeling the effects of their diseases in multiple aspects of their life. It also meant learning to deal with the consequences that resulted from behaviors brought on by bipolar disorder

and a comorbid substance use disorder. For participants in this study these effects resulted in loss of self-esteem and self-worth.

*Trying to escape.* Participants in this study described using drugs or alcohol as a means of escaping the symptoms of bipolar disorder. The practice of self-medicating was associated with attempts to escape feelings of depression, realities of their lives and the painful experiences in their past. Participants identified the need to escape the reality of living with the responsibilities of life such as parenting and managing financial needs:

Using allowed me to escape reality; I would feel like I was getting further and further from reality. The euphoria from being high on drugs had me feeling like I was just on top of the world. It gave me the euphoria of not having to worry about responsibilities. (Charles)

Participants also attempted to escape feelings of depression. They described having periods of extreme lows times when they would “just sit alone and cry.” They shared that the depression was so deep that they would just isolate themselves from the entire world. They self-medicated to escape from the despair and loneliness they associated with their depression:

When I was on a low, I tried to use drugs to kind of pep me up, put me back on that high. And, uh, it helped; well, to me, I thought it was helping me with the emotional side of it. It was making me feel good. (Lisa)

For some of the participants the depression was so deep they did not feel normal. They used drugs to numb their feelings. Participants used any type of drug and any amount of drugs; they thought would make their feelings of depression to go away:

I would use drugs. I would use; you know marijuana, alcohol, crack, opiate pills. They would make me feel normal because I couldn't feel my feelings, caused I numbed them all the time. I stayed high and I numbed everything. (Amy)

Participants discussed self-medicating in an attempt to escape the mood swings associated with bipolar disorder. Their mood swings were so out of control they just wanted them to stop. They were searching for a way to “level things out”:

I did have a drug problem but see I didn't know about my bipolar either so the drugs made me feel kinda level you know. I used because I wasn't on medicine and I was feeling up and down. I didn't know I was bipolar but it [drugs] helped level me out to make me feel good. (Kathleen)

Participants described using drugs in all phases of their bipolar disorder. It did not matter if they were euphoric or depressed, they used. They were seeking a way to stabilize their mood, trying to get “right between”:

If I crashed then I could hurt myself. I was trying to get leveled. The drugs made me feel better. So I used when I was happy to stay happy and I used when I was sad to get happy. Then I got hooked, I loved that drug and it would wind up killing me eventually. Cause I did anything to get that feeling. (Shirley)

Several participants experienced traumatic life experiences that left them with painful memories. They described the pain as an intense type of suffering, “you could feel it physically.” Participants spoke of the pain from the consequences they had suffered as the result of being an adult with bipolar disorder. They did not want to have these feelings, so they used substances to self-medicate because they did not want to feel anything at all:

It was like okay if I do drugs, I don't care, you know, 'cause that's what the drugs do, it just kills the pain, you know. Like prescription drugs kill physical pain, these drugs kill the mental pain. (Peggy)

The drug of choice for ten of the participants was cocaine. Participants used cocaine in the powder, freebase and solid forms. The effect of the cocaine, as they described it, was the drug's ability to help them escape from reality. It also freed them from feeling anything at all.

Two of the participants used alcohol, a central nervous system depressant. Participants who self-medicated with alcohol described drinking in an attempt to help them relax and relieve them of negative feelings.

For the participants in this study, self-medication was a way to escape, "even if it was only momentarily," from dealing with the issues surrounding their disorders. However, their attempts to self-medicate resulted in addiction complicating the symptoms of their bipolar disorder even further.

***Being pushed beyond the limits.*** All of the participants in this study had attempted suicide. They described being pushed beyond their ability to handle the difficulties in their lives. In an effort to manage being pushed beyond his or her limits, each participant attempted suicide at least once and often multiple times. The one male participant in this study had attempted suicide once. However, the eleven women in this study had attempted suicide three to five times. Participants did not describe their reason for attempting suicide as a will to die, but instead it was described as a way to seek relief. These participants wanted relief from the pain of traumatic experiences, failed life expectations, constant changes in mood states and bouts with deep depression. The levels

of lethality in the methods used by participants when they attempted suicide ranged from low to moderate (Kahan & Pattison, 1983). They used methods such as ingesting pills and poisons, cutting their wrist and “jumping,” which refers to jumping in front of a moving vehicle.

The eleven women in this study stated that they wanted relief of pain from traumatic experiences. These women had each experienced some type of traumatic experience such as rape or other sexual violation. Their suicide attempts were a way to free them of the pain so deep inside them:

Pain and hurt from my past dig into me. I tried suicide now altogether about four maybe five times. All of them I was taking pills and one time I tried to cut my wrist. (Gail)

Participants described a number of losses and disappointments in their lives, such as loss of children, marriages, and possessions. Additionally, all had problems in major relationships and role performance. These losses were perceived as failure to achieve life's expectations, which had become more than they could bear:

I tried to commit suicide several times. I would get so disgusted with myself from my drugs use, feeling less than. I was just giving up on myself and just wanted to take myself. I felt like, I don't have my kids, my life is not changing. (Donna)

Participants identified change in mood states as a reason for suicide attempts. Mood swings were constant, they did not seem to stop, whether they were on their medications or not. It had become more than they could live with so they attempted suicide to make it stop:

I was crying all the time, depression everyday, mood swinging because I was off the drugs, and you know, just snapped. I actually told people I wanted to die, “Ya’ll help me or I’m going to kill myself, because I don’t want to live like this anymore.” (Deb)

Suicide attempts were also a way to help participants who could no longer handle the deep depression and despair. They wanted relief from severe feelings of worthlessness, hopelessness and deep despair:

It got to the point where I threw myself in front of a truck, hoping the truck would knock me into traffic. I even drank some poison, Clorox. I felt down, really depressed, constantly. I just feel unworthy of myself, like I don’t want to be here, I’m not fit to be here. What’s the meaning of me being here? (Carolyn)

For participants in this study, the lived experience of being an adult with bipolar disorder and comorbid substance use meant living with pain, failed life expectations, changes in mood states and depression. The issues often become more than any one person could handle and pushed participants beyond their limits. They were desperate for relief and found it in suicide attempts. In most instances, they did not just reach their limits once but they found themselves in this place repeatedly. Participants were not suicidal at the time of the interview. Yet, some of the participants had just begun to explore the issues in their lives that resulted in their previous suicide attempts.

***Spiritual support.*** Participants defined the perceived, personally supportive components of their relationship with God as spiritual support. They believed spiritual support was important to their recovery from bipolar disorder and comorbid substance use disorder. They felt this way because spirituality was a fundamental skill in managing both their disorders. The relationship with God offered comfort, support, understanding,

unconditional love and forgiveness. Their personal relationship with God contributed to their sense of well-being. With God, they had a voice and when they cried out to God in prayer, “He heard” their prayers.

Participants did not talk about going to church or having a religious affiliation. They were all in active recovery and the 12-step recovery process is strongly rooted in a higher power and spirituality. Participants identified their belief in God as motivating. God was a higher power and a comforter with whom they had open communication through an active prayer life. During the interviews, the participants called God “higher power,” “Lord and Savior” and “awesome.” The participants believed they were alive because of God’s omnipotence:

My higher power is God, Jesus Christ. I pray every morning when I wake up. I pray every night when I go to bed, if it ain’t nothing but the Lord’s Prayer or something, but I pray something. I’m constantly walking through the house thanking Him for just being here today, because if it wasn’t for God’s help I wouldn’t be here, ‘cause he saved my life, he brought me through some hell.  
(Donna)

The comfort the participants found in God was a component of spiritual support that helped them endure whenever things were difficult. The comfort they received from God eased them:

I get on my knees and I really, I really get down and pray and it helps me. I do believe He is up there looking after me. Anytime I get in a tight situation or whatever, I can go to God. It helps me for some reason it calms me down where I can be able to function. (Joanna)

The participants said they communicated with God through prayer. They all described having fervent prayer lives. They felt their “constant” prayers to God were not only being heard, but were being answered:

I pray a lot. God is everything. He’s everything I pray a lot. I thank Him for waking me up in the morning and I pray every morning. I have suffered a lot, God erases it from my life. (Shirley)

God was there no matter what the situation was. No matter what had happened in their lives, having a personal relationship with God helped them through it. All the participants identified God as a higher power in their lives and found comfort in knowing that the support and unconditional acceptance of God was available to them.

*A negative connotation.* The participants in this study lived with the stigma of being an adult with bipolar disorder and comorbid substance use disorder. They had experienced being rejected, stereotyped, demoralized and devalued. There was a negative connotation associated with having either bipolar disorder or a substance use problem. However, stigma was a more complex issue for the participants in this study who had both bipolar disorder and a comorbid substance use disorder. The reason identified for being stigmatized by society included people thinking they were “crazy,” people thinking they were “bad,” and people not being willing to give them a “second chance.” They described feeling as if people treated them differently and looked down on them:

We are not actually crazy people you know, we’re not. We’re just people with emotional problems that don’t know how to handle them. We have feelings too (crying). We go through the same things they go through. People are afraid of you or they make fun of you. People can treat you so bad. (Gail)

Participants believed being perceived as abnormal was associated with being diagnosed with bipolar disorder and that being viewed as barbaric, immoral and irresponsible was associated with substance use disorder. They believed they were not recognized as being individuals who were sick and suffering from two disorders:

I'm normal as normal can be. I'm just like the next person, it's just like having diabetes. We can live like everybody else, but we have to be treated, we're sick. (Carolyn)

Participants in this study internalized their feelings of being stigmatized. As a result, they felt devalued and needed to validate themselves. When asked if there was one thing they wanted the public to know about them, all of the participants proclaimed, "I'm a good person." Participants wanted to make a positive contribution to society. But they did not believe they were given the same chance as adults without bipolar disorder and a substance use disorder. This was due to the stigma associated with their illnesses:

I'm a very polite well mannered person. I'm a good person. I want to do positive things but . . . dealing with stigma is one of the most disturbing things I can deal with. (Charles)

The participants had done things that were wrong but they wanted to be given a chance to reconcile their mistakes, most of which could be related to their illnesses. Participants were able to forgive and they wanted to be forgiven:

I am a good person even though I have a disease, and, uh, I was a good mother too. A lot of people look down on us but we're all good people and people just need to give us a second chance. (Shirley)

Even though the participants believed they possessed the basic good human qualities and the abilities of other adults in this world, living with the negative connotation of bipolar disorder and comorbid substance use disorder meant they would never be considered equal.

### ***Summary of Themes***

Six formulated themes were identified. The themes described how the participants managed their lives as adults with bipolar disorder and comorbid substance use disorder. Central themes identified were: *Life is Hard*, which described the challenges all participants faced in trying to manage their day-to-day life with bipolar disorder and comorbid substance use disorder. The theme *Feeling the Effects* gave light to the many consequences participants had to deal with as the result of being dually diagnosed. *Trying to Escape* related to the experiences of self-medicating to free self from the effects of living with their illnesses. Participants described the support and motivation they found which allowed them to move forward in life despite their illnesses in the theme *Spiritual Support*. The theme *Being Pushed Beyond the Limits* provides insight into the participants' feelings of desperation, feeling trapped and inability to manage. It also describes how these feelings lead to suicide attempts or a potentially life-threatening cry for help from the participants. Stigmatization was a common occurrence in the lives of the participants in the study. The theme *A Negative Connotation* explained what living with stigma was like for the participants.

The themes in this study captured the essence of being an adult with bipolar disorder and comorbid substance use disorder. The themes provided the participants' perspective of their illnesses and brought focus to the concerns of these individuals.

### ***Exhaustive Descriptions***

Descriptions of concepts and identification of consistent themes, exhaustive descriptions of the lived experience of adults with bipolar disorder and comorbid substance use disorder were developed. The exhaustive descriptions represent the experience as perceived by the participants.

1. Adults with bipolar disorder and comorbid substance use disorder experience the effects of their diseases in multiple aspects of their lives.
2. Being an adult with bipolar disorder and comorbid substance use disorder makes life hard for these individuals causing them to face challenges and struggles in day-to-day life.
3. These individuals self-medicate to escape the signs and symptoms of bipolar disorder as well as the pain, trauma and the residual effects of their diseases on their lives and relationships.
4. Adults with bipolar disorder and comorbid substance use disorder seek motivation and comfort in their spirituality and God.
5. Adults with bipolar disorder and comorbid substance use disorder want to overcome the stigma of their diseases and be accepted by society.
6. Adults with bipolar disorder experience hopelessness, worthlessness, and despair that often results in suicidal ideation and suicide attempts.

### ***Reflection on the Findings***

The purpose of this study was to understand and describe the lived experience of adults with bipolar disorder and comorbid substance use disorder. The findings as described were gleaned from face-to-face phenomenological interviews. Six themes emerged as distinctive to understand the problem of being dually diagnosed as perceived by the participants. For the participants in this study, who are adults living with bipolar disorder and comorbid substance use disorder, it means that you will experience hardship and consequences. You will spend your life constantly trying to balance, battling addiction and mood swings. Self-medication will seem to be a way to relieve symptoms of your illnesses. You will experience stigma and rejection. You will seek connection with a higher power from which you can receive comfort and support. Additionally, you may have times when you become hopeless and full of despair resulting in suicidal ideation and suicide attempts. However, through it all, you still feel like a good person and wish to be forgiven and accepted by society.

### **One Day at a Time**

As soon as IRB approval for this research study was obtained, the researcher began recruiting study participants. After waiting four months, the researcher had not received one call. Each day she waited anxiously for the phone to ring. The feelings of disappointment about not being contacted by potential participants grew more intense. The research proposal clearly spelled out a plan for recruitment but it was not happening the way she planned it. When the first participant contacted the researcher she was elated. Even though her plan had been slightly delayed, all she had to do was get back on the

path and move forward. It was not complicated at all, just get back on the path and move forward. For the participants in this study life was not that simple. Their life plans had been altered by bipolar disorder and comorbid substance use disorder. This made life more complicated and resulted in a number of issues that made moving forward extremely difficult. The participants in this study were not where they wanted to be and moving forward was not easy. Their walk in life would never be simple because they would always have to carry multiple issues associated with bipolar disorder and comorbid substance use disorder with them. Despite their challenges, they were trying to move ahead one day at a time. The researcher had successfully recruited and interviewed twelve wonderful people who were trying to get back on track. They were willing to share their story, they wanted to be heard and they wanted to make a difference. Through connecting with the participants the researcher had a greater appreciation of how uncomplicated her lifestyle was and how simple it was to get back on life's path and move forward. She just had to take it one day at a time.

### **Summary**

This chapter provides an overview of the twelve study participants. Data were collected from the participants through face-to-face, in-depth phenomenological interviews. The research question was, "What is it like living with bipolar disorder and comorbid substance use disorder?" Transcribed interviews were used to identify significant participant statements. Participants' significant statements were extracted, and formulated meanings that described the phenomenon of being an adult with bipolar disorder and comorbid substance use disorder were identified. Six distinctive themes

were developed and validated by the descriptions of the experiences of the participants. Participants in this study responded to a call for study participants because they wanted to tell their story and make a difference in the lives of those affected by bipolar disorder and comorbid substance use disorder. Each of the participant stated they found it therapeutic to talk to the researcher and share their story. However, knowing they had a voice and their story was going to be told helped the participants realize their self-worth. They expressed pride in knowing that there was interest in their story and it would be utilized to contribute to the gap in knowledge regarding their disorders. They also expressed delight in knowing that they could do something to help someone else. They stated that participating in this study allowed them to achieve this. The researcher was grateful to share their experiences with them and to be the instrument that made their voices heard.

## **CHAPTER V**

### **DISCUSSION**

#### **Introduction**

The purpose of this study was to describe the lived experience of adults with bipolar disorder and comorbid substance use disorder. Twelve adults were interviewed using a descriptive phenomenological approach. Participants' narratives revealed six themes as discussed in the previous chapter (1) *Life is Hard*; (2) *Feeling the Effects*; (3) *Trying to Escape*; (4) *Spiritual Support*; (5) *Being Pushed Beyond the Limits*; and (6) *A Negative Connotation*. This chapter explores the meaning of the themes and participant experiences in relation to current theory and past research. Implications for nursing practice, nursing research and health and public policy are discussed. Finally, study limitations and recommendations for further research are provided.

#### **Phenomenology Applied**

In keeping with Husserlian phenomenology, the researcher was able to bracket previous knowledge and experience with adults diagnosed with bipolar disorder and comorbid substance use disorder, which permitted participants to be perceived as they perceive themselves. Participants willingly discussed their experiences and struggles with managing their dual disorders. They spoke about suffering consequences, seeking spiritual support, and the trials of trying to be accepted.

In addition to bringing focus to associated behaviors and individual experiences, this study gave voice to the participants' personal meaning of health and life. Health meant conforming to treatment for their bipolar disorder and maintaining sobriety. Life was taking one day at a time and trying not to be destroyed by the mental, physical, and psychosocial consequences of their disorders. Overall, this study offers insight into the lives of the participants, providing an understanding of the lived experiences of adults with bipolar disorder and comorbid substance use disorder.

### **Themes**

#### ***“Life Is Hard”***

The first theme described how participants were challenged and their lives were consumed by both bipolar disorder and comorbid substance use disorder. Participants viewed their lives as unstable and difficult. Their lives were difficult because of the negative impact their illness had on everyday challenges as well as other health problems. Everyday challenges included life stressors, emotional instability, ineffective socialization, and dealing with the signs and symptoms of their illnesses. Because bipolar disorder and comorbid substance use disorder were interconnected, it was difficult to determine where one disorder began and one ended. Participants expressed to others that they faced difficulties and challenges, yet the ability for people to understand and heed their concerns was absent. They did not believe people heard them when they spoke of the difficulties they faced. Thus, they identified all these feeling as life being hard.

The findings of this study are consistent with those of Pollack, Cramer and Varner (2000), who conducted a quantitative analysis of hospitalized patients with bipolar

disorder and comorbid substance use disorder and bipolar disorder only. Sixty-two patients with bipolar disorder and a secondary diagnosis of a substance use disorder and 60 patients who were diagnosed with bipolar disorder only were included in the study. The group comparison was made to determine if a secondary diagnosis of substance use was associated with less favorable outcomes on self-reported measures of mood, subjective distress, and behavior/symptom identification. Participants in this study with both disorders rated themselves as functioning significantly worse than individuals who were diagnosed with a single disorder. Pollack et.al, identified comorbid substance use disorder as complicating the symptom presentation for patients with bipolar disorder. From the participant's perspective, being diagnosed with both bipolar disorder and a comorbid substance use disorder contributed to difficulties in psychosocial functioning, interpersonal relationships, self-directed violence, emotional liability and substance abuse.

Life was hard for the participants in the current study because they were trying to manage multiple health issues including HIV. The findings of the current study support those of Kilbourne, Cornelius, Han, Pincus, Shad, Salloum, Cornigliaro and Haas (2004), who describe clinical overlap and interactions between bipolar disorder and medical comorbidity. A descriptive study of 4,310 veterans who received at least one inpatient or outpatient diagnosis of bipolar disorder reported a high prevalence of comorbid medical conditions, including cardiovascular (hypertension) and endocrine (hyperlipidemia and diabetes) diseases, chronic obstructive pulmonary disease, infectious disease (hepatitis C), and musculoskeletal conditions (e.g. low back pain). The purpose of the study was to

identify the presence of medical comorbidities in adults with bipolar disorder. More than one-third of the respondents with bipolar disorder were given a diagnosis of three or more comorbid medical conditions; the risk for medical comorbidity was significantly higher in the group with diagnosed bipolar disorder at an earlier age (compared with the reference group). However, interactions between medical comorbidity and the functional status were not reported.

HIV was an additional health issue identified by three participants in the current study, as making life difficult. Patients with mental illness and substance use disorder are at significant risk for developing HIV (Blank, Mandell, Aiken & Hadley, 2002). Substance use, especially injection drug use, frequently co-exists with other psychiatric symptoms such as impulsivity, cognitive impairment, or hypersexuality, any of which can increase HIV risk.

The findings of the current study are consistent with those of Levin (2007). Patients diagnosed with mental illness, substance use and HIV were referred to as having “triple diagnosis” (Levin). Triple diagnosis refers to being diagnosed with mental illness, substance use and HIV. Triple-diagnosis patients face daunting problems such as unemployment, poverty, poor housing, legal problems, and lack of social support (Levin).

Participants in this study had difficulty with social interactions and relationships. According to the National Alliance on Mental Illness [NAMI], (2003), dually diagnosed patients have great difficulty developing social relationships. These patients are not easily accepted and are marginalized in social situations. Mowbray, Ribisl, Solomon, Luke and Kewson (1997) conducted a descriptive study on 486 dually diagnosed patients from an

urban psychiatric inpatient setting. The purpose of the study was to determine social and community functioning, particularly concerning African-Americans with a dual diagnosis in the public sector. A comprehensive array of clinical, social and community functioning measurements were used. An assessment of community and social functioning, alcohol and drug use, psychiatric problems, and service histories was also conducted. The majority of participants were found to have serious economic and employment problems, undesirable living arrangements, limited or conflictive family or social relationships, and some record of arrests.

The findings in the current study echoed the findings of NAMI (2003) and Mobray et al. (1997). The participants talked about facing challenges with coping in their social life, managing other health issues and just trying to live with having both bipolar disorder and comorbid substance use disorder. They spoke of how complicated their lives were and described having hard times. Participants attested they were constantly trying to manage the difficulties in life. They believed family, friends and health professionals, despite the fact there was information available concerning their disorder, did not understand the challenges they faced. Others did not understand they had two disorders. It was hard for participants to try to convince people they were not crazy or drunk but they were living with two challenging disorders. Participant's perception was that their disorders were interconnected and there was constant movement between both disorders while trying to manage life's challenges. In the structured world of recovery, the participants did not focus much on the challenges they faced and believed the support to manage daily life was currently available and adequate. However, they would have to

reintegrate into the community and manage their challenges alone. There is a need for the establishment of support networks and local management agencies, which support these individuals. Support upon community re-entry will reduce the rate of relapse and suicide attempts in this population.

### ***Feeling the Effects***

The second theme described the consequences of being an adult with bipolar disorder and comorbid substance use disorder. The effects of their diseases were all encompassing, touching every aspect of their lives. For the participants, being an adult with bipolar disorder and comorbid substance use disorder meant living with the negative consequences of their diseases. There was a long list of effects associated with being diagnosed with bipolar disorder and comorbid substance use disorder. The participants stated that they had engaged in risky behaviors, experienced physical consequences such as acquiring HIV and pancreatitis, and a criminal record. They had damaged relationships and credibility with family and friends. Material possessions were lost along with their financial stability.

The current study findings are consistent with those of Lim, Nathan, O'Brien-Malone and Williams (2004) who conducted focus group discussions and individual interviews with 18 bipolar patients to understand the problems experienced by bipolar patients and meanings associated with their experiences. Lim et al. found bipolar patients view their lives as being characterized by loss and deficits. Participants' responses revealed that the onset of bipolar disorder is not only a life-changing experience in itself, but also brings about changes that for many patients may last a lifetime. These changes

include the breakup of relationships, loss of employment and financial status, and alienation from friends and family. These findings are supported by the current study. However, the current study explored these problems in adults with bipolar disorder with the complex issue of substance use disorder.

To obtain a greater understanding of perceived negative consequences of having a dual diagnosis, Bender et al. (2007) studied fifty-seven outpatients with bipolar disorder and substance use disorder (Bender et al.). The researchers measured negative consequences of substance use, to determine if patients with substance use disorder and bipolar disorder could identify which disorder was related to or contributed to their difficulties. Outpatients diagnosed with bipolar disorder and substance use disorder experienced negative consequences of their diseases including interpersonal, intrapersonal, physical, social, and impulse issues (Bender et al.). Interpersonal problems included issues with family and close friends. Intrapersonal problems were associated with guilt, shame, and damage to their reputation. Physical and social problems were money, appearance and physical illness. Impulse issues included foolish risks or accidents. While some negative consequences overlapped, patients could differentially attribute certain negative consequences to one disorder or the other.

The participants in the current study had experienced loss, deficits and negative consequences interpersonally, physically, socially and in their intrapersonal lives. The damage to their reputation resulted in them not being accepted by family, friends and society. They attributed negative consequences to bipolar disorder or substance use disorder. Violent behaviors that resulted in imprisonment were related to the irrational

thoughts brought on by bipolar disorder, and prostitution and stealing were related to their substance use disorder. The participants in this study described these negative consequences as being the direct effect of both bipolar disorder and comorbid substance use disorder. All the participants in the current study were in a structured recovery setting at the time of the study. This meant they had shelter, food, clothes and were in a community where they were accepted. However, once they left recovery they would have the task of managing these negative consequences without support. The effects or consequences had a major impact on the lives of adults with bipolar disorder and comorbid substance use disorder and their ability to function in society “like normal people.”

### ***Trying to Escape***

The third theme that emerged from the data was trying to escape. The participants in the current study had all used drugs to escape the signs and symptoms of their bipolar disorder. Participants in this study cited self-medication of psychiatric symptoms as an important motivation for substance use and openly disclosed that they used substances to relieve them of the pain from past traumatic experiences to calm them, to numb them and to manage their feelings of depression. Self-medication was part of living with bipolar disorder and comorbid substance use disorder.

The self-medication hypothesis provides a possible explanation for this practice. The hypothesis posits that substances are used to relieve specific psychiatric symptoms, leading to repetitive use (Khantzian, 1997). There is a plethora of literature which identifies self-medication as a primary motivator for substance use in patients with

bipolar disorder (Bizzarri et al., 2007; Judd et al., 2002; Kasten, 1999; Khantzian, 1997; Weiss, 2004; Weiss et al., 2004).

Kasten (1999) conducted a qualitative descriptive study using participant observation to examine the experiences of mentally ill adults with co-occurring substance use disorders. Twenty dually diagnosed persons in recovery who had depression or schizophrenia and a substance use disorder were studied. Almost one-third of the sample described using drugs or alcohol to relieve periods of depression. However, the findings from the current study explored the lived experience of adults with bipolar disorder and captured the behavior of self-medication among the bipolar participants.

Bizzarri et al. (2007) conducted a study to examine the spectrum of alcohol and substance use, including reasons for use, in patients with bipolar disorder. The study specifically focused on the relationship between substance use, substance sensitivity, other comorbid psychiatric symptoms and traits related to sensation seeking. The researchers studied 57 patients with bipolar disorder and alcohol or substance use disorder. Most of the patients with bipolar disorder and substance use disorder reported that they frequently used substances in order to alleviate mood and anxiety symptoms, and to increase energy.

This study's findings support Bizzarri et al. (2007) as the participants in this study all perceived that they self-medicated using drugs or alcohol to improve their mood and ability to function. However, current study's findings were inconsistent with those of Bizzarri et al. (2007) which identified a relationship between sensation seeking and substance use. Sensation-seeking was defined as seeking intense emotions from

substance use such as extreme euphoria similar to that of a manic episode. In the interviews conducted in the current study, none of the participants described using drugs for sensation-seeking or trying to reach a level of euphoria or a high that mimicked a manic episode. Participants stated that they used substances to rid them of their feelings altogether. In their significant statements, they described trying to feel “numb,” “leveled-out,” or “better.” They also described escaping reality. Participants in this study described using drugs to rid them of signs and symptoms of low periods in their lives or trying to find balance between their ups and downs. Additionally, the participants all stated that while they used drugs to self-medicate and escape signs and symptoms of bipolar disorder, they recognized that it was only temporary. These findings suggest that self-medication is as equally ineffective in providing these individuals with relief from their symptoms as medications prescribed to treat the symptoms of their bipolar disorder.

### ***Being Pushed Beyond the Limits***

The fourth theme which emerged from the data analysis was being pushed beyond the limits. The twelve participants in this study had all experienced suicidal ideation and had attempted suicide. Their suicide attempts were described as a way to obtain relief from the chaos and problems occurring in their lives. Findings in this study revealed factors associated with the participants’ suicide risks were history of traumatic experiences, failed life expectations, changes in mood state, and extreme depressive episodes. The participants found attempts at suicide to be a way to manage the pain, life and reality itself. There was a high prevalence of suicide among the participants in this study and a number of them had attempted suicide more than once. These findings were

consistent with other studies and reviews of outcomes of bipolar illness with substance use comorbidities (Comtois, 2004; Dalton, Cate-Carter, Mundo, Parich, & Kennedy, 2003; Goldfarb, 2001). The reported prevalence of suicide attempts is 39.5 percent in individuals with bipolar disorder and comorbid substance use disorder (Dalton et al., 2003).

Purifacion, Mosquera, Deleon, et al. (2001), in an investigation of the association between suicide attempts and predictive factors followed 169 patients identified with bipolar I disorder. More than one third (56) of the patients had a history of one or more suicide attempts. The rates of suicide attempts were much higher in patients with onset of bipolar disorder at or before the age of 25 years than in patients with onset after age 25 (25% vs. 10%, respectively). Other factors related to suicide were drug abuse, family history of affective disorders, and severe depressive episodes. The patients who abused drugs had a history of more suicide attempts than those who had not abused drugs.

To identify clinical predictors of suicide attempts in subjects with bipolar disorder, Dalton et al. (2003) studied 336 subjects with a diagnosis of bipolar I, bipolar II, or schizoaffective disorder (bipolar type). The Structured Clinical Interview for DSM-IV (SCID-I) was administered and predictors of suicide attempts were examined in attempters and non-attempters. The lifetime rate of suicide attempts for the entire sample was 25.6%. A lifetime co-morbid substance use disorder was a significant predictor of suicide attempts: bipolar subjects with co-morbid substance use disorders had a 39.5 percent lifetime rate of attempted suicide, while those without had a 23.8 percent rate.

Lifetime co-morbid substance use disorders were associated with a higher rate of suicide attempts in patients with bipolar disorder.

Suicide risks have been found to be markedly elevated in patients with bipolar disorder and comorbid substance use (Goldberg, 2001). Suicide risk may arise for patients with bipolar disorder and substance use disorder as an outcome, which may result from the loss of predictable mood states and the loss of functional capabilities. This leads to risk for suicide that patients are likely to act on (Potash et al., 2000). Methods of attempting suicide for this population may involve higher degrees of aggression and potential medical lethality (Elliot et al., 1996).

All twelve participants in the current study had attempted suicide. Only one of the 12 participants had attempted suicide once; however, 11 had attempted suicide between three to five times. They had used methods such as cutting, overdosing, poisoning and jumping in front of moving vehicles.

The findings of Goldberg (2001), Potash et al. (2000), and Elliott et al. (1996) are supported by this study. Participants experienced suicide risks because of negative outcomes of their diseases and because they had come to feel they could not take it anymore. However, their level of suicidal lethality was low to moderate, even though they experienced intense ideation. This study's findings indicate a need to determine if patients with bipolar disorder and comorbid substance use disorder have a will to die or are using suicide as a cry for someone to save them. There is also a need to capture more information to determine if the methods chosen and level of intent demonstrate suicide attempts as attention-seeking events. While suicide attempts are commonly viewed as a

negative effect or consequence, for the participants in this study at the peak of a crisis it was the gateway to getting help.

The literature shows a strong relationship between suicidal ideation and suicide attempts in individuals who are diagnosed with bipolar disorder and comorbid substance use disorder (Comtois et al., 2004; Dalton et al., 2003; Feinman & Dunner, 1996; Lopez et al., 2001; Potash et al., 2000; Tondo et al., 1999; Weiss et al., 2005). The risk of suicide is often increased in people with co-occurring disorders who present with multiple risk factors such as change in mood states, depression, and socioeconomic factors (Dalton et al., 2003; Potash et al., 2000; Sublette et al., 2008). Predicting suicide in individual patients is difficult. No studies examined suicide attempts as a coping mechanism in this population. Based on the experiences of the participants in the current study, there is a need to further explore this. Suicide is an important issue in the assessment, management, and treatment of person with bipolar disorder and comorbid substance use disorder. In an effort to save lives, reducing suicide risk must remain a priority in meeting the health needs of these individuals.

### ***Spiritual Support***

The fifth theme in the study was spiritual support, which described the support from a higher power. Participants in this study described feeling supported by God. Having a spiritual connection made them feel supported and contributed to their motivation to remain sober and compliant with treatment for bipolar disorder and substance use disorder. Having a relationship with God gave them a good feeling. It made them feel protected and worthy. They also felt like they could rely on God to be there

when no one else was to help them work through their most difficult times in managing their disorders. The participants all talked about having a fervent prayer life in which they prayed several times a day.

Goldfarb, Galanter, McDowell, and Lifshutz (1996) pointed out the need for more attention to spirituality in treatment planning and in designing research on dually disordered populations. One hundred and one patients in a dual diagnosis inpatient unit and 31 members of the nursing staff were surveyed about the importance of spirituality to these individuals. They also examined perceptions of the importance of spirituality in recovery from dual disorders. Fifty-nine percent of patients viewed spirituality as central to their recovery. They also were interested in groups focused on spirituality and wanted more access to religious services in their treatment program.

The current study supports Laudet, Magura, Vogel, and Knight's (2000) stance that spiritual support and a relationship with a higher power contributes to the well-being of patients who are dually diagnosed. Laudet et al. (2000) investigated association among social support, recovery status and personal well-being in 310 dually diagnosed clients. Spiritual support was assessed using an adapted version of the Spiritual Well Being Scale. The clients in the Laudet et al. (2000) study viewed spirituality as a path to recovery for these patients, citing that dually diagnosed patients had high levels of spirituality and placed importance on such issues. This indicates a need for nurses to be more cognizant of the spiritual orientation of patients with bipolar disorder and comorbid substance use, and to support their efforts at spiritual development.

Attendance at worship services, meditation and prayer are all identified as characteristic behaviors of spirituality (Hammond & Rassool, 2006). Taking part in religious spiritual practices is an integral part of recovery programs for individuals with dual diagnosis. These practices are used to help dually diagnosed patients improve interconnectedness with self, others and the environment (Hammond & Rassool, 2006). Spiritual practices provided support and acceptance.

Spirituality transcends religion and can be the essence of nursing those with a dual diagnosis (Hammond, 2003). Models for continued involvement in religious services and practices past discharge from a structured recovery program need further investigation. Hammond (2003) suggests the integration of a humanistic model of spirituality with a person-centered focus in the care of dually diagnosed patients.

The participants in the current study were all in active recovery programs at the time of their interview. In their recovery program, a focus on spirituality and participation in religious services was an integral part of their treatment. Staying connected spiritually through prayer or religious activities met the spiritual needs of the participants in this study. They verbalized that they experienced a source of comfort from their spirituality. These study findings suggest that the participant's needs for spiritual support were being met while they were actively engaged in the recovery process.

Finally, in the southern U. S. fundamentalist and evangelical Christianity is taken very seriously. Spirituality and Christianity are a dominant part of Southern culture. In the U. S., the region where the Southern Baptist Convention dominates is where Christianity and Spirituality are strongest (Willis, 2000). The current study took place in

the Southeastern U. S., which may have had an impact on the perception of the need for spiritual support.

### *A Negative Connotation*

The final theme in the study refers to the stigma associated with bipolar disorder and comorbid substance use disorder. Stigma can be a challenge to ones' humanity and is personally, interpersonally and socially costly (Biernat & Dovidio, 2000). Participants in the current study all described the experience of living with the stigma associated with their disorders. They described being seen as crazy, lazy, immoral, and irresponsible rather than human beings who are suffering from two severe chronic illnesses.

The primary social factor influencing health care for patients with bipolar disorder and substance use disorder is stigmatization. Stigma creates a barrier to a fulfilling life, held not only by nameless strangers, but also by friends, family, and health care providers (Thornicroft, 2006). Mental Health: A Report of the Surgeon General (Corrigan, 2004; Satcher, 1999) identified stigma as one of the major barriers that discourage adults with mental illnesses from seeking treatment. Consequences of discrimination and stigma for adults with bipolar disorder and comorbid substance use disorder include lowered self-esteem, disrupted family relationships, increased difficulty in building connections in the community, securing housing, and obtaining employment.

Stigma harms people who are publicly labeled as mentally ill in several ways. Stereotyping, prejudice, and discrimination can deprive people labeled as mentally ill of important life opportunities, which are essential for achieving life goals (Corrigan, 2004). People with mental illness are frequently unable to obtain good jobs or find suitable

housing because of the prejudice of key members in their communities: employers and landlords. Several studies have shown that stereotypes and prejudice about mental illness have an impact on obtaining and keeping good jobs and finding safe housing (Bordieri & Drehmer, 1986; Farina & Felner, 1973; Wahl, 1999).

Substance use and mental illness are frequently misunderstood and stigmatized. Sokratis, Scott, Serfaty, Weich, and King (2004) conducted interviews with 46 mentally ill patients. Thirteen of the participants were dually diagnosed. The patients reported feelings and experiences of stigma. Stigma was experienced in forms of verbal abuse, loss of contact with others, patronizing attitudes and discrimination. The effects of stigma for the patients were feeling sad/bad, angry, fearful, guilty, embarrassed, and isolated. Suffering from both disorders increases the stigma and ultimately creates social isolation for dually diagnosed patients. Patients with bipolar disorder and a substance use disorder experienced discrimination that was more overt. Patients with bipolar disorder and substance use disorder reported experiencing violence and verbal use possibly related to unusual behaviors provoking negative reactions (Sokratis, 2004). Even some treatment providers and physicians will shun and avoid working with these clients (Dino, Stevens, Serfaty, Weich, & King, 2004).

Living in a culture infused in stigmatizing images, persons with mental illness may accept these notions and suffer diminished self-esteem, self-efficacy, and confidence in one's future (Corrigan, 1998; Holmes & River, 1998). Research shows that people with mental illness often internalize stigmatizing ideas widely endorsed within society

and believe they are less valued because of their psychiatric disorder (Link, 1987; Link & Phelan, 2001).

Biernat and Dovidio (2000) describe stigma as a mark or sign designating the bearer as defective, resulting in individuals feeling less valuable and abnormal in comparison to others. Stereotypes of stigmatized individuals often cause them to be viewed as negative and violent. The outcome is rejection and degradation in social interactions that leads to isolation (Biernat & Dovidio, 2000).

In the current study, participants found living with the negative connotations of their illnesses difficult and it was a struggle to be accepted. Most of them described stigma as being the most difficult issue to manage. The stigma of their disorders brought them a sense of embarrassment. A diagnosis of both bipolar disorder and substance use disorder resulted in participants believing others viewed them differently. Participants believed they were viewed by society as crazy and psychotic. Therefore, people did not want to deal with them or made fun of them. Participants believed having diagnosis of a substance use disorder resulted in them being viewed as irresponsible and reckless. Because of this perception of them they were treated as such, no matter how hard they tried to live a lifestyle that proved differently. Stigma was ranked highly important to participants' ability to be contributing members of society. Participants wanted to be valued, and having bipolar disorder and a comorbid substance use disorder had caused them to feel devalued. Internalization of their feelings was the result of being stigmatized. There was a need to identify themselves as good people in an effort to rise above the perception that society did not see them as such. Participants wanted a second chance to

prove they were of some value to society. Further research is needed to explore factors that may assist these individuals to cope with feeling devalued and strategies to influence society's attitude about their value in society. Studies exploring the effects of internalized feelings of stigma on the emotional state of individuals with bipolar disorder and substance use disorder are also needed.

Participants in this study identified being misunderstood and lack of information regarding bipolar disorder and comorbid substance use disorder within society as major contributors to stigma. Public information programs and educational measures aimed at selected target groups to improve the public's knowledge are indicated. Programs for families, and resource providers should focus on information regarding symptomatology, causes, and treatment options for persons with bipolar disorder and comorbid substance use disorder. Improved knowledge will decrease prejudice and negative perceptions while facilitating social reintegration of those suffering from bipolar disorder and comorbid substance use disorder. Participants in this study experienced stigma, which created a number of barriers in their lives.

### **Living with a Dual Diagnosis of Bipolar Disorder and Substance Use Disorder**

Additional aspects of the lives of adults living with both bipolar disorder and comorbid substance use disorder emerged for the researcher as she spent time immersed in the transcripts of the interviews, one being which diagnosis came first, bipolar disorder or substance use disorder. There is great debate in the literature surrounding this issue (Bizzari et al., 2007; Cassidy & Carroll, 2001; Strakowski, DelBello, Fleck, & Arndt 2000). The findings in the current study support those of Strakowski and Delbello

(2000) who hypothesized that substance use may trigger bipolar disorder. Ten of twelve participants in the current study were diagnosed with a substance use disorder prior to being diagnosed with bipolar disorder. Several participants believed their bipolar symptoms such as mood swings were present prior to being diagnosed with the disorder. Participants stated a definitive diagnosis of bipolar disorder was only after their addiction was clearly identified and the symptoms they believed were associated with bipolar disorder had become more intensified. Substance use results in chemical changes in the brain that predispose persons to bipolar disorder (Townsend, 2007). The current study indicates substance use disorder was the primary diagnosis in the study participants and bipolar disorder was a secondary diagnosis.

The current study's findings on substance of choice are inconsistent with those of Bizzarri et al. (2007), who state that dually diagnosed patients used alcohol more frequently as the substance of choice. Eight of the twelve participants in this study identified cocaine as the drug of choice. Participants in this study who used cocaine stated it helped them "escape reality." They described using cocaine as their drug of choice because it gave them a feeling of numbness. One participant used opiates as the drug of choice, which had been prescribed for chronic back pain. This was the drug of choice because it was easily available. For this participant, opiates served as the gateway drug to cocaine. Only three of the participants used alcohol as the drug of choice. Alcohol was the drug of choice for these participants because it made them happier, was easier to obtain and they had began drinking at a young age.

Further studies are needed to provide insight into the selection of drug of choice in adults with bipolar disorder and comorbid substance use disorder. A clearer understanding of which drugs are being used and which symptoms are targeted is needed. It is also important to determine what drugs are viewed as accessible and affordable. The physical and social consequences of the drugs chosen must be explored. This information is necessary to meet health care needs within this population.

In an effort to develop the meaning of the lived experience of dually diagnosed individuals, the meanings and values these individuals attach to their experiences must be explored and validated (Barker, 2001). The current study allowed the researcher to engage with participants in an ordinary way using everyday language, which helped the researcher capture the experience of being an adult with bipolar disorder and comorbid substance use disorder. Participants were elated the exhaustive descriptions had captured the essence of their experiences. Their experiences had been validated and given credence. Participants attached value to their experiences being captured and believed the exhaustive descriptions were important to understanding who they were.

Participants voiced they did not believe they were heard or understood. Not being understood made participants feel as if they did not have a voice and were not valued. They spoke of being misunderstood by family members and healthcare providers alike. Being misunderstood made life difficult and complicated their ability to relate to others. They told of family, friends and health care professional who did not understand the impact of these illnesses on their lives. Others did not understand the psychosocial, socioeconomic, and physiological burdens of their diseases and the limits it placed on

their lives. This resulted in demands being placed on participants they were unable to meet. The current study validates the findings in the literature (Barker, 2001; Corrigan, 2005; Shattell, McAllister, Hogan & Thomas, 2006; Turgal, 2003) regarding the importance of these individuals being understood.

This study's findings support the need to improve resources for individualized health plans and education (SAMHSA, 2000) for these clients. A key finding of this study was the participants' lack of understanding about his or her diagnosis. The participants were all actively in recovery and attending group sessions in which they were receiving information about bipolar disorder and comorbid substance use disorder. Several participants stated they still did not understand bipolar disorder. They also did not understand the terms "comorbidity" or "dual diagnosis." A mini mental status exam of the participants revealed the participants were alert and oriented. The participants were going to the doctor and had regular access to health care professionals. Yet, they still did not think they were knowledgeable about their disorder. Participants believed they needed more education and knowledge about their disorders.

Individual educational plans based on patients' learning levels and styles are needed to improve education in this population. This can be accomplished through improved assessment of learning needs and improved delivery of health information to these clients. Client-centered education models are needed as well. An examination of health providers' perceptions of quality of education provided to adults bipolar with bipolar disorder and comorbid substance disorders use may improve the delivery of health information (Shayo, O'Connell, & Beyer, 2000). Recovery programs, which

saturate clients with information, must remain a priority in the treatment of adults with bipolar disorder and comorbid substance use disorder.

The interconnection between bipolar disorder and comorbid substance use disorder made it difficult for participants to identify which disorder was the root cause of challenges they faced in life. During the interviews, participants spoke of issues such as financial challenges, psychosocial challenges and physiological effects of their disorders. They also spoke of drug of choice such as cocaine and alcohol. However, it was not always clear for them whether the challenges they faced and their drug of choice were correlated with bipolar disorder or substance use disorder. Several times during the interviews, the researcher had to ask the question: “Are you talking about bipolar disorder or substance use disorder?” The participant’s response was “both.” This indicates a need for a better understanding of how bipolar disorder and substance use disorder link to psychosocial and physiological factors as well as drug of choice. Treatment priorities focusing on root causes of these factors can be more effectively established. Health care of adults with bipolar disorder and comorbid substance use disorder may then be improved.

Kovito, Janhonen, and Vaisanen (2004) conducted a study using a qualitative phenomenological approach of nine voluntary participants. The aim of the study was to determine how patients experienced being helped while having psychosis. The study findings indicated that participants felt it was very important to be understood and respected as a human being. Furthermore, the study demonstrated that care should focus on the patient’s real experiences and provide understanding of the patient’s whole

situation. This gave a voice to the patients' inner experiences and empowered them to cope with daily life. The current study supports the findings of Kovito, Janhonen, and Vaisamer (2004) regarding the importance of giving a voice to patients' inner experiences. Several of the participants found it reassuring that the researcher was interested in listening to their stories. Participants identified having a voice and someone to talk to about their disorders as a motivating factor for participating in this study. Participants wanted to discuss their health issues and concerns. This demonstrates the value of interactions between adults with bipolar disorder and substance use disorder and health care professionals. These interactions should focus on open discussion of the individuals true experiences while trying to grasp an understanding of their life situation.

### **Summary**

The first assumption of this study was that participants would be willing to talk about their experiences. All the participants in this study spoke openly of their experiences. The second assumption of this study was that it is possible to understand how people make sense of what happens in their lives (Locke, Sporduso, & Silverman, 2007). The researcher understood the participants in the study. The essence of the lived experience of being an adult with bipolar disorder and comorbid substance use disorder was also captured.

This study revealed six exhaustive descriptions, which described the lived experience of adults with bipolar disorder and a comorbid substance use disorder. Adults with bipolar disorder and comorbid substance use disorder experience the effects of their disorders in multiple aspects of their lives. Participants face challenges and struggles in

day-to-day life. Participants self medicated to escape the signs and symptoms of bipolar disorder as well as the pain, trauma and residual effects of their disorders on relationships and in their lives. Participants sought motivation and comfort through their spirituality and a higher power. They wanted to overcome the stigma of their disorders and be accepted by society. However, there were times when they experienced hopelessness, worthlessness, and despair that often resulted in suicidal ideation and suicide attempts. Life was difficult for the participants in this study. They lived with the burdens of both disorders daily. Participants complied with treatment regimens and ceased to use substances, yet their lives did not improve. The burdens of living with their disorders continued and became progressively worse. These descriptions give insight into the lived experience of being an adult with bipolar disorder and comorbid substance use disorder.

### **Conclusions**

This study captured the experiences of twelve adults diagnosed with bipolar disorder and comorbid substance use disorder. Study participants talked about the subtleties and complexities of their experiences. Participants lost their ability to be productive citizens because they were constantly trying to manage the effects of both bipolar disorder and substance use disorder. Participants were also trying to overcome the consequences of these poorly managed health issues. The stigma associated with their disorders also made them feel like they were not valued. Participants sought comfort, acceptance and forgiveness in spiritual things. Most importantly for the participants was the need to be heard, accepted and forgiven by society. Acceptance and forgiveness

would allow them to move forward and maintain a successful recovery. Others could then see their worth and give them opportunities to be productive in society.

### **Implications for Nursing Practice**

Nurses need to broaden their view and knowledge of bipolar disorder and comorbid substance use disorder. Maintaining ongoing dialogue with patients about their experiences is important. Nurses must question how these patients' feelings can continue to be expressed as they move through healthcare centers and recovery programs. This dialogue will assist nurses in creating individualized plans of care based on patients' needs. Specifically, plans of care that focus on interventions for coping and managing the effects of bipolar disorder and comorbid substance use disorder. Mental health nurses should assist in the development of self-management within the framework of individualized plans of care (McBride, 2007). Nurses can improve the evaluation of medication effectiveness and contribute to better relief of symptoms. Nurses must also improve patient education about the effects of using substances to relieve symptoms. Nurses must educate patients and help them to understand that relief of symptoms through substance use does not provide them with better symptom management than that of prescription medications. Yet, the side effects of prescription medications are less severe than those of substance use. Nurses need to increase vigilance in screening for suicidal ideation and improve the ability to identify high-risk patients. All the participants in this study attempted suicide, therefore monitoring and screening patients for suicide risk is imperative. Nurses must not only identify risk levels and help patients with current

crises, but they must also assess for underlying issues that may increase the risk of suicide. This will help save lives.

Nurses must become more aware of the spiritual orientations of patients as well as their own. This will increase nurse's sensitivity to the spiritual needs of patients (Townsend, 2007). Nurses need to incorporate spiritual models into the care of patients with bipolar disorder and comorbid substance use disorder. This can be accomplished through collaboration with interdisciplinary team members such as chaplaincy representatives. Nurses caring for patients with bipolar disorder and comorbid substance use disorder must advocate for them in the health care community. Nurses providing support for the development and enforcement of policies that protect this population can accomplish this. This may decrease stigmatization among this population. Nurses must also encourage patients to speak out about stigma in an effort to reduce internalization of patients' feelings. When patients are unable to speak out, nurses must be their voice. Finally, nurses must join professional organizations serving as advocates who lobby at the legislative level for allocation of funds and parity among the mentally ill. This will position nursing to call for equality and the improvement of services where there are gaps.

Participants in this study had the courage to speak about this complex issue at a crucial time during their recovery. Such issues as whether and how to disclose information about one's psychiatric problems are important to address. This study demonstrates the need for participants to interact and connect with nurses and health care professionals. Nurses as well as other health professionals can use interactions with these

patients as a time to reach out to these individuals and build on their strengths and not just addressing their deficits. These individuals will then have an opportunity to move forward on the health and wellness continuum. Forming bonds with these individuals will allow nurses to contribute to helping patients recognize their value and help to improve their quality of their life. Good nursing practice means assessing completely, medicating effectively and educating thoroughly.

### **Implications for Nursing Education**

This study supports the need to keep in-depth psychiatric nursing education courses and clinical experiences required for students and practicing nurses. Recent changes in the mental health care delivery system have resulted in nursing education in the area of mental health to be reduced (Townsend, 2007). This study shows the devastating effects of bipolar disorder and comorbid use in this population.

In pre-licensure nursing education, an emphasis must be placed on enhancing student comfort in caring for this population of individuals. Neophyte nursing students identify negative attitudes of fear and mistrust of the mentally ill as common reasons why psychiatric nursing was the least favored career option (Penn, 2007). Waite (2006) suggests a need for improvement in the approach to the introduction of nursing students to psychiatric mental health nursing. Thus, strategies that enhance student comfort in psychiatric clinical settings will assist in increasing the effectiveness of the learning experience. Additionally, these strategies may increase the interest in psychiatric nursing as a career choice and help alleviate a critical shortage of psychiatric nurses (Penn, 2007). Strategies include, training psychiatric staff to work with students, development of a

consistent structure around psychiatric clinical experiences, and meeting essential knowledge needs related to the psychiatric setting (Burnstein, 1998; Penn, 2007).

Currently practicing nurses need continued emphasis on nursing education in mental health. Nurses can gain competence in completing comprehensive health assessments, improving interpersonal relationships and assuring patient-centered care practices in these adults. There is a need to educate nurses to use assessment techniques to capture clearer, more accurate information regarding suicide risk, self-medicating behaviors, and religious preferences. In adults with bipolar disorder and comorbid substance use disorder, this will improve evaluation and identification of health status, suicide risks and spiritual needs of these patients. Nurses should also be taught to use information from previous lapses and relapses as opportunities to capture assessment data needed to revise care. Nurses' ability to advocate will be increased.

This study also supports the need to continue to educate nursing professionals about the therapeutic use of self when caring for patients with mental illness. Nurses need to be educated on strategies for creating non-judgmental interactions with their clients. Nurses can learn strategies in the use of self and be more open in the nurse-client relationship. As a result, nurses receptiveness in interactions with these clients, will allow them to hear the clients' voices and increase the experience of genuine empathy. Therefore, feelings of being devalued in adults with bipolar disorder and substance use disorder can be decreased.

Graduate nursing education must focus on training nurses to serve as advanced practice nurses in clinical settings. Nurses trained as clinical experts in the field of mental

health nursing to meet the needs of this population in the practice setting. Graduate nursing education should also assist nurses in developing skills to serve in roles as nurses in academia and science. Nurses in academia assist in the development in the skills needed to prepare the future generation of nursing experts needed to care for mental health clients. As well as, nurse scientists who research and explore theories and models of care are needed to manage the health of adults with bipolar disorder and substance use disorder. Finally, graduate education is needed to train nurses to create and disseminate information regarding the health and health needs of adults with bipolar disorder and comorbid substance use disorder. This will bring awareness to the needs of these individuals.

### **Implications for Nursing Theory**

This study has implications for nursing theory. Newman's theory Expanded Health as Consciousness (Newman, 1986) was the sensitizing framework used in this research study. Newman proposes health is not the absence of disease. However, she identifies it as the identification of patterns and behaviors, which result from the presence of disease. The awareness of these behaviors and patterns become embedded into the conscious of these individuals. The results are individuals becoming more aware of life as they live it, as well as the patterns and behaviors that affect interactions with other people in the world. The themes that were identified in this study suggest that there are patterns and behaviors common to the phenomenon of the lived experience of adults with bipolar disorder. It also suggests that further explorations of these behaviors are needed to provide a conceptual framework and platform for meeting the needs of these individuals.

A clear theoretical understanding and articulation of the lived experience of adults with bipolar disorder and comorbid substance use disorder will provide a common language and a point of comparison for nurses that have potential for universal application.

Sandelowski, Docherty, and Emden (1997) suggest for qualitative findings to have an impact must be situated in a greater theoretical context and “be presented in an accessible and usable form in the real world of practice” (p. 365).

### **Implications for Nursing Research**

This study supports the need for more research on bipolar disorder and comorbid substance use disorder. The role of the nurse in the future requires an interface between clinical practice and research for patients with bipolar disorder and comorbid substance use disorder. Nurse researchers should focus on basic science, clinical research to investigate the existence of biological markers for these mental illnesses. There is a need for nurse researchers to develop outcome studies with instruments that accurately measure quality of life and functional status in order to intervene. Nurse researchers must find ways to improve methods of symptom management to decrease and prevent substance use in adults with bipolar disorder. There also is a need for a more detailed examination of the value or benefits of interpersonal interactions between nurses and patients. Additionally, the benefit of these interactions and patients’ feelings of trust with nurses needs to be investigated. There is a need for studies on the perception of nurses regarding their experience of caring for these patients. The research question “Do nurses caring for adults with bipolar disorder and comorbid substance use disorder perceive therapeutic interactions effective?” can help qualify the value of the nurse patient

therapeutic interactions. There is also a need for intervention studies in this population to address the issues of self-medication. Research questions such as “What is the lived experience of adult patients who self-medicate?” may help identify interventions to decrease self-medicating in this population. Studies to improve identification of factors that predict suicide and suicide risk are needed. The research question, “What are factors that predict suicide attempts in adults with bipolar disorder and comorbid substance use disorder?” should be asked to lower suicide attempt rates. This researcher was unable to identify any existing evidenced-based practice that guided the care needs of bipolar patients with comorbid substance use disorder. This indicates a need for evidence-based practice research in this population.

### **Implications for Health and Public Policy**

The community mental health revolution of the past forty years has brought about profound changes in mental health care across the U. S. Public hospitals have been downsized, alternative inpatient and outpatient treatment settings have proliferated, and reliance on drugs and other new therapies has increased (Hackney & Rochefort, 2001). Less than one in every six patients with serious mental illness received treatment that could be considered minimally adequate. This translates to 8.5 million individuals with serious mental illness in the U. S. who do not receive adequate treatment each year (Wang, Demler, & Kessler, 2002). Key segments of the population with mental illness continue to suffer from neglect and deprivation associated with limited housing opportunities, vulnerability to crime and abuse, and high rates of institutionalization (Frank & Glied, 2006).

According to the final report of the New Freedom Commission of Mental Health, there needs to be a drastic reorganization of the mental healthcare system. Financing approaches for programs that serve the mentally ill are complex, fragmented and inconsistent with coverage. Additionally, public policies such as the Mental Health Parity Act (MHPA) and the Community Mental Health Centers (CMHC's) Act, which were created to provide equality and facilitate improved services, are proving to have a number of gaps. Gaps in parity are evidenced by insurance plans that have greater restrictions on treating mental illnesses than on other illnesses. This prevents some individuals from getting the care that would dramatically improve their lives. Mental health benefits have traditionally been more limited than other medical benefits (CMH, 2003). Omissions in funding programs are also a shortcoming of mental health policies. CMHC's were intended to advance community care of people with mental illness and assist states in deinstitutionalization. However, CMHC's were funded with block grants that did not provide mainstream health and social welfare resources; rather these programs required specific and periodic authorization and appropriation from Congress (Goldman & Grob, 2006). Federal health care programs such as Medicare and Medicaid, as well as private insurance programs do not adequately address the delivery of mental health care. Health policies, which enhance the health and well-being of this group, are those that promote an understanding of what is mental illness and reduce the stigma of mental disorders, are desperately needed.

This study is important and relevant to healthcare policy because it addresses mental disorders, one of 28 focus areas identified by the National Center for Health

Statistics in its Healthy People 2010 initiative (NCHS, 2006). Dissemination of the study's findings will answer the call for research that reduces the burden of mental illness in patients and families. The study contributes to a better understanding of the experiences of adults with bipolar disorder and comorbid substance use disorder. With this clearer understanding of these individuals, interventions programs needed may also be developed. The goal of improving quality mental health service among the mentally ill will be met.

There is evidence in this study as well as others that illuminate the vulnerabilities of adults with bipolar disorder and comorbid substance use disorder. Symptoms of bipolar disorder are difficult to manage and complicated by comorbid substance use disorder. These adults experience physical, psychosocial and economic consequences. Their lives are at risk because they have an increased incidence of suicide attempts and they are more likely to have high levels of suicide-related deaths. Policy development is necessary for these individuals. Policies and acts to build infrastructures for mental health and substance use services are needed. Policies that support the establishment of local management entities are also indicated. Local management entities are agencies of local government responsible for managing, coordinating, facilitating and monitoring the provision of mental health and substance abuse services (Frank & Glied, 2006). Finally, policies to appropriate funds for the expansion of services and support for persons with mental health and substance use disorders are essential.

### **Limitations**

The limitations of this study are those inherent in the use of a qualitative research approach. This study is limited to the conditions under which the study was carried out, specifically the sample. This study was limited to twelve individuals who were all currently residing in a recovery house, so generalizability of these findings is limited. Another limitation of this study was a lack of gender diversity. Despite a variety of recruitment techniques, snowballing provided most of the study participants, which results in more women participants than men (Sixsmith, Boneham, & Goldring, 2003). Therefore, the snowballing technique yielded eleven females participants. There was only one male participant in the study. Additionally, all the participants were actively living in the structured setting of a recovery house and in the active recovery process. Not all adults with bipolar disorder and comorbid substance use disorder are in a structured setting. The current study has only exposed the surface of a very complex phenomenon. Many complexities of the phenomenon have yet to be understood.

### **Recommendations for Future Research**

Several important questions have emerged from the study findings. Participants did not understand their bipolar disorder. There is a need for improvement in the educational process of adults with bipolar disorder and comorbid substance use disorder. A study looking at the type and effectiveness of education provided to this population is indicated. Additional research may also increase compliance with treatment regimens, and improve identification of crises to increase earlier intervention in these individuals.

Each woman participant in this study identified experiencing an earlier event of sexual assault, which occurred prior to the participant being diagnosed with bipolar disorder or substance use disorder. These women practiced self-medication as a way to relieve themselves of the pain and hurt from sexual or physical abuse. Research is needed to determine the relationship between bipolar disorder and/or substance use disorder and a history of sexual or physical abuse. Research in this area may help reduce the incidence of self-medication and improve coping mechanisms to manage the pain of experiences of sexual or physical abuse.

All of the participants identified bipolar disorder and comorbid substance use disorder as having an effect on their relationships with their children. This ranged from long periods of separation, loss of custody and complete loss of contact with their children. A study examining how their parenting has been affected by both disorders could address this question. Of all the effects of being diagnosed with bipolar disorder and comorbid substance use disorder, this area was most important to all of the participants. Studies focusing on the effects of being dually diagnosed on parenting may improve relationships between these patients and their children.

Research focusing on the relationship between substance of choice and symptoms of bipolar disorder are needed. Reduction of self-medication behaviors is pertinent to improving the health status of these individuals. Interventions to manage symptoms leading to self-medication will decrease substance use in these individuals.

Research on a larger scale, including statewide and multiple state studies will increase the generalizability of the study's findings. Diversity of the research sample will

be enhanced. The experiences of adults with bipolar disorder and comorbid substance use disorder who live independently in their homes or independent living communities also will be captured.

Research to improve assessment techniques for suicide risk in this population is needed to decrease the number of suicide attempts in this population. Research to identify resource needs of individuals with bipolar disorder and comorbid substance use in an effort to provide support before suicide attempts occur is indicated. Evidence-based suicide prevention programs so that crises can be managed without suicide attempts must also be developed. Both qualitative and quantitative research addressing these questions will further enhance the body of knowledge available to practitioners working with individuals who are dually diagnosed with bipolar disorder and substance use disorder.

One of the major accomplishments of this study was providing the participants with a voice. Outside of the connection with their higher power, participants described feeling as if they were not heard. This was evidenced by their behaviors and feelings of devaluation. It is imperative that nurses, health care professionals and society recognize that people with bipolar disorder and substance use disorder need to be heard. In their voices are requests for help and support. These individuals are pleading for forgiveness and acceptance by society. Responding to their need for support can improve outcomes. Ultimately, it will lead to a decrease in suicide attempts and may save lives.

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**Appendix A**  
**Probe Questions**

**“Describe for me what it is like living with bipolar disorder and a substance use disorder?”**

**“Describe for me a typical day that would help me understand what your life is like.”**

**“How did you feel when you were told you had both bipolar disorder and a substance use disorder?”**

**“Describe for me what it is like living with bipolar disorder and a substance use disorder?”**

**“Could you elaborate on this?”**

**“How does this effect you?”**

**“You talked previously about ...can you tell me more about that?”**

**“What do you think about ...?”**

**“What did you do then?”**

**“What do you want people to know about your disorder(s)?”**

**“Why do you think that is?”**

**“How did that make you feel?”**

**“Last time we talked about ...” “Is there anything you would like to add that you didn’t talk about?”**

## Appendix B

### Consent

**UNIVERSITY OF NORTH CAROLINA AT GREENSBORO**  
*CONSENT TO ACT AS A HUMAN PARTICIPANT: LONG FORM*

Project Title: The Lived Experience of Adults with Bipolar Disorder and Comorbid Substance Use Disorder

Project Director: Terry D. Ward

Participant's Name: \_\_\_\_\_

**DESCRIPTION AND EXPLANATION OF PROCEDURES:** The purpose of this study is to develop an understanding of what it is like to be an adult with bipolar disorder and comorbid substance use disorder. You have been invited to participate because you are 18 years of older and have a DSM-IV diagnosis of bipolar disorder and a DSM-IV diagnosis of a substance use disorder. You are being asked to commit up to 3 hours of your time for 1 or 2 face to face interviews which may last up to one hour each. An additional meeting in person or over the telephone may be required for you to review the findings from your interview. The times and places we meet will be at your convenience.

By signing this form you understand the interviews are being tape recorded, however the researcher, Terry Ward, will be shredding the tapes after the interviews are transcribed into a written text. The taping is done to assure that the researcher is able to capture all of your words. Terry Ward may take notes during the interviews and your name will not be recorded on these notes and will only be identified by a numerical code. Your name will not be identified with the written transcript and only a numerical code will identify written materials at any time. All research material will be stored in a locked file cabinet in the researcher's office. Consent forms will be keep separate form the interview material to assure confidentiality. Transcripts, which are numerically coded, will be stored on a password protected computer. All written materials will be destroyed after the study is completed. Consent forms will be kept for 3 years and then will be destroyed by shredding.

**RISKS AND DISCOMFORTS:** There are no known risks or discomforts for you participating in this study. You may talk about things that become stressful for you and if you feel the conversation is too stressful you may ask that the tape recorder be turned off and the interview be stopped. Also, at any other time you may ask that the tape recorder be turned off, and at that time the researcher will turn off the tape recorder and ask you if you would like to stop the interview.

**POTENTIAL BENEFITS:** Little is known about what it is like for individuals living with bipolar disorder and comorbid substance use disorder. Information you provide may help nurses and other health care professionals learn what this experience is like so we can provide better care and assist with providing services needed. There will be a \$US 20 monetary incentive given for your participation in this study.

By signing this consent form, you agree that you understand the procedures and any risks and benefits involved in this research. You are free to refuse to participate or to withdraw your consent to participate in this research at any time without penalty or prejudice; your participation is entirely voluntary. Your privacy will be protected because you will not be identified by name as a participant in this project.

The University of North Carolina at Greensboro Institutional Review Board, which ensures that research involving people follows federal regulations, has approved the research and this consent form. Questions regarding your rights as a participant in this project can be answered by calling Mr. Eric Allen at (336) 256-1482. Questions regarding the research itself will be answered by Terry Ward by calling 919-308-1802. Any new information that develops during the project will be provided to you if the information might effect your willingness to continue participation in the project.

By signing this form, you are agreeing to participate in the project described to you by Terry Ward

\_\_\_\_\_  
Participant's Signature\*

\_\_\_\_\_  
Date

**Appendix C**  
**Significant Meanings**

<b>Participant 0003R</b>	<b>Significant Meanings</b>	<b>Category</b>
I've been running a race with crack-cocaine for fifteen years.	Addiction	Drug use & addiction
Everything can be going good; you know what I'm saying? I have real, real highs	Euphoria	S/S of BPD
I've got real, real highs and then all of a sudden I just get depressed	MS	S/S of BPD
Just some days I got real, real highs and then I get real, real, real depressed,	MS	S/S of BPD
I can be fine and then and nothing be happening, no incident happen or something and I just feel; I don't know if you would say, not really angry, but real agitated, you know what I'm saying? Frustrated	MS Frustration	S/S of BPD
I get manic, man. I'll be flying around here cleaning up. I'll have four or five projects going on at one time Everything's just, you know, lovely.	Manic	S/S of BPD
I don't want to get up. I won't eat. I'm sick' and it's really I'm depressed and I just can't, you know, pinpoint exactly what it is	MS-Down	S/S of BPD
I'd like to know more about it because I don't know about it	Lack of Knowledge	Knowledge of the dz
I'd like for it to be broke down to me to where I can kind of understand it and hopefully somebody that's experienced with it try to work and pinpoint my issues so I can, you know, get grips with it because I don't understand it	Lack of Knowledge	Knowledge of dz

<b>Participant 0003R</b>	<b>Significant Meanings</b>	<b>Category</b>
I used everyday crack. When I got on crack I used, especially at the end I used crack every day, all day long	Addiction	Drug Use & Addiction
I'd stay up four or five days at the time. I'd go four or five days without eating. I've gone a couple of days without even drinking water. All I would do is smoke crack and sit in the hotel room and smoke crack.	Addiction	Drug Use & Addiction
It took everything I had from me. It took a marriage, it took cars, it took my self-esteem. It took my self-worth. It put me to doing things that I would have never ever done in my life. I stole from my mother, prostituted, writing checks; stealing other people's checks and credit cards. Um, just about any and everything short of hurting somebody physically.	Loss Stealing Prostitution	Consequences of Dz
I could never stay steady nowhere, could never hold a job, you know. Um, and it just escalated unruly. Drug treatment court was the best thing that ever happened to me.	Recovery Loss	Trying to recover Consequences of Dz
I got a drug charge and I got put in jail and as a part of a plea bargain they threw one of the, because I had two possession charges, possession of cocaine	Crime	Consequences of Dz
Well somebody introduced me to heroin I realized I had a real bad habit, you know what I'm saying? And then I started, you know, prostituting to get it. I'd be real sick. Um, it felt like I was going to die without it, you know?	Addiction Prostitution Sick	Drug Use & Addiction Consequences of Dz

<b>Participant 0003R</b>	<b>Significant Meanings</b>	<b>Category</b>
I'd be like . . . and even other people would say, what's wrong all of a sudden?" "Nothing's wrong man." I'd noticed it a few years ago but I just medicated, self-medicated it, you know.	Self medication	Self Medication
I did a lot of things, you know, that I'm ashamed of	Shame	Stigma
I want recovery this time,	Recovery	Trying to recover
I lost him, I lost the trailer, I lost my mother, everything within a year's time I've lost	Recovery	Trying to recover
I lost my fiancé because he's going to school to be a minister but he was trying to get me straight, you know, get me off drugs and I just wouldn't quit, you know	Loss Addiction	Consequences of Dz Drug Use & addiction
I have to go to mandatory NA meetings, um, I go to a NA meeting or a women's group	Recovery Peer support	Trying to recover