CASE REPORT

Alcohol Dependence With Seasonal Bipolarity And Self-Medication For Psychotic Symptoms: A Case Report

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Abstract : *Affective and psychotic symptoms are often found in patients with alcohol dependence, and may present with significant diagnostic difficulties. Self-medication with alcohol for such symptoms has been described for affective but not psychotic symptoms. We present a case with alcohol dependence with seasonal bipolarity who self-medicated for psychotic symptoms.*

Key Words: Alcohol dependence, seasonal bipolar, self-medication

INTRODUCTION

The comorbidity of alcohol with psychiatric symptoms is widely documented. Up to 80% of alcohol dependent patients complain of depressive symptoms and 30% or more fulfill criteria for a major depressive episode.[1-2] Alcohol dependent cases also have at least a three times higher risk for bipolar disorder, compared to the general population.[3] However, some authors have questioned this high rate, asserting that substance-induced hypomanic or mania-like clinical condition could be misdiagnosed as an independent bipolar disorder during acute or protracted withdrawal from alcohol.[4]

We present the case of an alcohol dependent male who had seasonal affective symptoms during some of his alcohol withdrawal episodes and who self-medicated with alcohol to ameliorate his auditory hallucinations.

THE CASE

A 40 year old married male electrician pre-morbidly well adjusted and with family history of alcohol dependence in father, presented with history of alcohol use for 23 years, including 17 years in a dependent pattern with tolerance, craving, impaired control over use, neglect of work and family, and characteristic withdrawal symptoms like irritability, restlessness, mild tremors and insomnia. In the first 11 years of alcohol use even though he did not make any serious attempt to quit alcohol, he tried to cover his withdrawal symptoms with gradually escalating doses of up to 135 mg of dextropropoxyphene capsule or up to 60-80 mg of nitrazepam or 30-40 mg of diazepam tablet on each occasion up to twice a month; he stopped these for the fear of unspecified harm to health. His drinking continued to increase further and for the last 4 years he was drinking heavily, even in daytime, with associated severe socio-occupational dysfunction.

During these four years under family pressure he stopped alcohol 9 times spread over all seasons. On each occasion, he experienced withdrawal symptoms (anxiety, irritability, tremors and insomnia) for the initial 4–5 days of abstinence. On four out of nine times (between April and July every year) withdrawal symptoms were followed by sadness of mood, easy fatigability, slowness in the activities, absenteeism, low confidence, and pessimistic ideation about having wasted his life and the future of his family being bleak. There were associated decreased appetite, sleep, and self-care, and constipation. There was no history suggestive of decreased attention and concentration, ideas of hopelessness, or suicidal ideas.

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The above 'depressive' symptoms would last for 4–5 days and would be followed by 1–2 days of hearing of voices in the evening for 4–5 minutes on 5–6 occasions in clear consciousness. The voices would be of 2–3 men of a neighboring family, be abusive and derogatory, and he would act on them indulging in verbal altercation with neighbors. There was no sadness, altered sensorium or disorientation associated with the period of hearing voices. Ascribing the hearing of voices to loss of sleep due to stoppage of alcohol and to prevent himself from 'going crazy' he would resume alcohol intake. The psychotic symptoms would promptly terminate and he would continue drinking in a dependent manner with no affective or psychotic symptoms till his next abstinence attempt after 4-5 months.

About 2 months before admission he stopped alcohol, had withdrawal symptoms as described above for 4–5 days and after remaining well for 10 days, started becoming irritable, overactive, over talkative and unduly generous in his dealings. He also had decreased need for sleep and increased libido. After 2 weeks in this state, he restarted taking alcohol, due to craving. All the above symptoms subsided soon thereafter.

The review of the course of symptoms led to a conclusion that during the last four years his affective and hallucinatory episodes were secondary to alcohol withdrawal in summer months (5 out of 9 non-summer alcohol withdrawals had not been associated with affective and hallucinatory episodes). Hence, the management focused on alcohol dependence, emphasizing on relapse prevention strategies. Disulfiram was started with informed consent. It was decided to withhold psychotropics at present and institute them later if the affective or psychotic symptoms reappear in the absence of alcohol use.

DISCUSSION

The case had several points of interest. To start with, there was a diagnostic dilemma whether the mood symptoms were due to an independent disorder or secondary to alcohol use. The short lasting nature of depressive and psychotic symptoms, absence of family history for affective/ psychotic illness and the temporal association with an alcohol withdrawal state support the diagnosis of an alcohol-induced disorder. However, not all episodes of alcohol withdrawal were associated with behavioral symptoms. The seasonal pattern was another key feature, which has been described in independent affective disorder, but not in association with alcohol induced mood states.

The other unique point in the case was the recurrent use of alcohol by the patient to terminate hallucinations. Khantzian has proposed a model of substance abuse that asserts that some drug-dependent individuals select a drug of choice to provide relief from specific painful affective states, particularly depression and anxiety. This model is popularly known as the self-medication hypothesis.[5] However, we could find no reports of self-medication of alcohol to terminate psychotic symptoms. On the contrary, available literature suggests that alcohol use exacerbates, rather than improves, psychotic symptoms and is associated with increased hallucinations and decreased treatment response.[6,7]

This case illustrates diagnostic difficulties encountered in relation to comorbid substance use and psychiatric symptoms. The diagnosis in such cases will usually be clarified in the long-term follow up. The goal should be to maintain abstinence from alcohol and follow up closely for any psychiatric symptoms; emergence of symptoms during abstinence will clinch the diagnosis of an independent psychiatric disorder.

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