Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery: A Review of the Literature*

Update

Reviews Literature From June 2010 through December 2010

Treatment Improvement Protocol (TIP) Series

48

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UPDATED FINDINGS FROM THE LITERATURE, DECEMBER 2010

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Updated Findings From the Literature, December 2010

This Treatment Improvement Protocol (TIP) Literature Review update includes findings published between October 2009 and December 2010.

Screening and Diagnostic Issues

Most articles on this topic reiterated the previous findings that people entering substance abuse treatment are not adequately screened for depression.

A study performed by Hepner and colleagues (2009) noted that practitioners working in substance use disorder (SUD) treatment programs generally do not have training in the diagnosis and treatment of depression, and that fewer than 7 percent of individuals entering substance abuse treatment are screened for depression. To assess screening instruments that could be used in a treatment setting, the researchers compared two commonly used assessment instruments designed to diagnose depression: the Beck Depression Inventory Second Edition (BDI-II), and the Patient Health Questionnaire (PHQ-9), a nine-item depression scale originally developed for use in primary care settings. The researchers administered the instruments to 240 residents in 4 residential SUD treatment facilities. These instruments were highly correlated with each other.

The measures revealed similar rates of symptoms of moderate to severe depression. However, the PHQ-9 seemed to detect a higher rate of mild depressive symptoms than the BDI-II, which was more likely to categorize clients as having minimal symptoms. Results suggest that both measures can be used to assess depression symptoms in patients who have an SUD. However, the PHQ-9 may be more sensitive in identifying patients with fewer depression symptoms. In addition, this measure is shorter than the BDI-II, easier to administer, and available at no cost. One limitation of the study was that only 65 percent of the sample was screened within the recommended 14–30 days after admission to an SUD treatment facility.

In another study of depression and SUDs, Niciu and colleagues (2009) differentiated subtypes of major depressive episodes (MDE) using secondary data in people diagnosed with SUDs. The researchers looked at records of 1,929 subjects with SUDs and found 863 subjects who experienced one or more MDEs. The people who had MDEs were categorized by the type of MDE, which resulted in three groups:

- Subjects who had experienced MDEs independent of SUDs
- Those with substance abuse-induced MDEs
- Those who had experienced both types of MDEs

The study found that patients in the third category (i.e., those who had experienced both types of MDEs) who experienced both independent and substance abuse-induced MDE have more severe depression than those in the other two categories. The authors suggested that these patients may need more intensive and longer duration psychiatric care than the patients in the other two groups. Furthermore, the study verified earlier research that found that individuals with depression often self-medicated with alcohol. The authors also found that those patients who had

both substance-induced MDE and MDE independent of SUDs along with an anxiety disorder, were more likely to have attempted suicide than other study subjects.

Gamble et al. (2010) studied 1,726 patients who had participated in Project MATCH (Matching Alcoholism Treatment to Client Heterogeneity), a clinical trial of behavioral treatments for alcohol use disorders (AUDs). The study attempted to assess whether depressive symptoms predicted the level of alcohol use following completion of treatment. Patients were from two groups: an outpatient group composed of those who had not recently completed any inpatient care; and an aftercare group of patients who had completed at least 7 days of inpatient or intensive outpatient care.

The researchers measured depressive symptoms and alcohol use (i.e., drinking frequency and intensity) at the end of the treatment and during the following year. They found that pretreatment BDI-II scores were significantly associated with percentage of days abstinent and average number of drinks per drinking day, although the effect was not significant if posttreatment BDI scores were factored in. Posttreatment depressive symptoms were significantly associated with the measures of alcohol consumption; patients with more severe depressive symptoms showed increased alcohol consumption after treatment. Therefore, the researchers recommended that patients completing treatment for AUD be screened for depression before being discharged from treatment. However, the study did not address the effects of drinking on depressive symptoms. Furthermore, the study relied on self-reports and did not address whether the depressive symptoms were related to intoxication or withdrawal. It is also not clear *why* posttreatment depression is related to frequency and duration of drinking after treatment discharge.

Rodriguez and colleagues (2010) performed a similar study using data from the Brief Intervention and Treatment for Elders (BRITE) project, a Florida program that provided brief interventions for older adults who screened positive for misuse of alcohol or medication. The study addressed the extent to which higher levels of depressive symptoms were associated with greater levels of alcohol use. The 366 subjects who had positive alcohol screens ranged in age from 53 to 100, with a mean of 73.8. Nearly 71 percent of the subjects had no or mild depressive symptoms. The study found that people with either moderate or severe depressive symptoms were at greater risk for problems with alcohol use than those without. However, this association decreased with age and virtually disappeared by the age of 80.

Having a high school education also reduced the risk of being a problem drinker. The authors concluded that patients in the age range of 53 to 100 years should not be treated as a homogeneous group, and that special screening and intervention are warranted. The authors identified the reliance on self-reporting as a limitation of the study, although they referred to research that has found this data-collection approach to be reliable. They also note the cross-sectional design and methods that providers used to select participants as being potential design limitations.

Nonpharmacological Treatment

Five of the articles focused on treatment of co-occurring SUDs and depression in a treatment setting, and the effect that one condition has on the treatment of the other, particularly the effect of depression on SUD treatment.

Lydecker et al. (2010) performed a longitudinal study that followed 206 veterans who had co-occurring depression and SUDs who were randomly assigned to receive 24 weeks of either integrated CBT (ICBT) and medication for depression (ICBT + P) or 12-Step facilitation therapy (TSFT + P) plus medication for depression (TSFT + P). Participants agreed to random toxicology screening and 135 participants completed the study. Substance use and depression symptoms were measured at intake and every 3 months during treatment and 1 year after completing 24 weeks of treatment. The study found that participants in both groups had decreased substance use and depressive symptoms compared to measures at the start of the study. However, the ICBT + P group had less substance use and depressive symptoms than the TSFT + P group. Better attendance at treatment sessions was associated with improvements in substance use and depressive symptoms. One limitation of the study was that it consisted of veterans who were mostly male and cannot be generalized to other treatment populations.

Van Zaane and colleagues (2010) assessed the effect of alcohol use on the treatment of bipolar disorder. The prospective 1-year study evaluated alcohol use by 137 subjects who were being treated for bipolar disorder. By assessing alcohol consumption over a 4-week period, researchers divided the subjects into three groups according to level of alcohol consumption: none or incidental, moderate, or extensive. Researchers tracked the subjects' alcohol consumption for 1 year based on their self-reports. Contrary to previous research findings, drinking at any level had no effect on the effectiveness of treatment of bipolar disorder in this study. The authors hypothesized that the results' contrast from previous studies resulted from differences in research methodology and characteristics of the subject population, such as illness severity and substance usage. They stated that, "close monitoring with monthly assessments of the patients may have had a positive effect on outcome, and a possible reason why the negative effects on outcome of excessive drinking were nullified" (p. 891).

In assessing a less commonly used treatment approach, Witkiewitz and Bowen (2010) studied mindfulness-based relapse prevention (MBRP) to determine whether this approach would lessen the conditioned response of cravings. MBRP combines cognitive–behavioral relapse prevention with mindfulness practice. In this approach, clients meditate for 30–45 minutes in a group session and 45 minutes individually with audiotaped instructions. The purpose of this approach is was to increase clients' awareness and acceptance of negative emotions and cognitions related to depression. The authors hypothesized that the increased awareness and acceptance, in turn, would reduce cravings through lowered reactivity to depression-related emotions and thoughts. The study population consisted of 168 clients completing treatment for SUDs, 73 percent of whom completed the 4-month assessment. The control group completed the same treatment regimen, and then underwent a standard aftercare program, which was based on the 12-Step model. The subjects reported their cravings and use at the beginning of the study, at the end of the 8-week course, and at 2 and 4 months following the study. The study showed that MBRP could help clients cope more effectively with affective discomfort during early abstinence by reducing cravings. However, the authors did not assess the impact of MBRP on long-term

abstinence; they recommended additional study regarding the uses and benefits of this treatment modality, as well as development of more objective measurements.

Secora et al. (2010) studied psychosocial and cognitive functioning related to cannabis dependence among 108 patients, half of whom also had depression, and half who did not. The subjects had sought treatment in response to public solicitations. The authors used the Addiction Severity Index (ASI) to measure psychosocial limitations and dependence and the California Computerized Assessment Package to measure cognitive functioning. As found in previous studies, the researchers found that patients with both depression and cannabis addiction showed a decrease in psychosocial functioning. Unexpected, however, was the finding that these patients actually scored slightly *higher* on tests measuring cognitive functioning than those in the group not addicted to cannabis. The authors, therefore, recommended increased intervention related to psychosocial functioning, but not increased intervention related to cognitive functioning.

Pharmacological Interventions

Pettinati et al. (2010) assessed the effectiveness of naltrexone and the antidepressant sertraline as treatments for co-occurring AUDs and depression. Patients were recruited from the general community and screened for AUDs and depression. The 170 subjects were randomly assigned to four groups:

- Patients taking naltrexone only
- Patients taking sertraline only
- Patients taking both medications
- A placebo group

All patients received weekly CBT sessions; 57 percent completed the study. After 14 weeks, the researchers found that the patients receiving both naltrexone and sertraline were more likely than those taking only one of the medications to have been abstinent from alcohol, had delayed relapse to heavy drinking, and tended to not be depressed. However, the researchers cautioned that the results could not necessarily be generalized to a treatment population, because the patients were recruited from the community and self-selection bias may have affected the outcome.

Methodology

The methodology used in the development of TIP 48 was used in the preparation of this update (see http://www.kap.samhsa.gov/products/manuals/tips/pdf/TIP48_LitRev.pdf).

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