The Effect of Treating Major Depressive Disorder
On Alcohol Dependency Disorder
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Abstract

Alcohol dependency and depression are very common disorders currently confronting our healthcare system. They tend to co-occur, which can lead to increasingly severe and problematic healthcare outcomes. One of the major controversies is how and when to treat people when Major Depressive Disorder (MDD) and Alcoholic Dependency Disorder (ADD) are present. There is some disagreement about treating depression while substance abuse is ongoing. This literature review examined 16 empirical articles regarding the prevalence of depression and alcohol dependence in a variety of populations and age groups. Factors impacting relapse were also researched. Sex and age differences in response to treatment were also investigated. The implications found in this literature review were significant. It was found that the need for rigorous screening and treating of MDD in the alcoholic population is critical. Untreated MDD can lead to early relapse and self-medication. The need for early detection and prevention of symptoms and behaviors that precede MDD and ADD is discussed. Supporting individuals with this dual-diagnosis was seen as critical.
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Introduction

Alcohol dependency and depression are very common and costly disorders confronting our health care system today. They tend to co-occur, which leads to increased severity and problematic health care outcomes. Many plans have been proposed to improve the screening and diagnosis of depression in alcohol use disorders. These plans are commonly used in many mental health or addiction treatment programs. One of the major controversies in the field is about how and when to treat people when depression and alcoholism co-exist. A central question is the decision whether or not to treat the depression while substance abuse is ongoing. Some clinicians recommend treating the depression alongside the substance abuse. Other clinicians are reluctant to begin treatment for depression until the patient has succeeded in accomplishing significant duration of sobriety. These clinicians are concerned that it is difficult to differentiate between substance induced depression and true depressive disorders.

DSM Criteria for MDD

The DSM-IV (2000) provides the diagnostic criteria for both Major Depressive Disorder (MDD) and Alcohol Dependence Disorder (ADD). In reviewing the DSM-IV findings, it is important to note that each disorder clearly identifies substance abuse as a potential differential diagnosis.
The essential feature of MDD is a clinical course that includes one or more major depressive episodes. It identifies these episodes of lasting at least two weeks during which there is depressed mood or loss of interest or loss of pleasure in all activities. People must also have at least four additional symptoms from a list that includes: changes in appetite and weight, changes in sleep patterns, decreased activity and energy, feelings of worthlessness or guilt, difficulty thinking, concentrating or making decisions, or recurrent thoughts of death/suicide plans or attempts. To be included in a diagnosis of a major depressive episode, these symptoms must be newly present or have clearly worsened when compared with their pre-episode status. The person must experience these symptoms daily for two consecutive weeks. The person must be experiencing significant distress or impairment in social and/or occupational functioning. It is of interest to note that the DSM-IV clearly states that MDD stands apart from a substance-induced mood disorder. A study done by Parker et al. (1987) clearly indicated the interrelationship between alcohol use and depression in a household survey of over 1,300 men and women in the Detroit, Michigan area. They discovered that after controlling for factors such as age, income, education, medication use and parental drinking, that increase quantity of alcohol consumed for drinking occasions was associated with increased depressive symptoms in the sober state among women and men. The key aspect of the study was that the drinking and depression was related to the amount of alcohol ingested in single sessions of drinking, as opposed to the frequency of alcohol consumption.
Adlerian View of Depression

The Adlerian view of depression is that it may be derived from anger. The individual may feel anger that has not yet been identified or has been turned inward, in that the individual may have difficulty expressing their anger, or not feel entitled to feeling it.

The key for treating depression would be to help the individual identify their anger by delving into their past and assessing issues that may have caused the anger. This could be done by using techniques such as early recollections or lifestyle analysis. This would be conducted in a 1:1 therapy session. However, group therapy is valuable, as it legitimizes the feeling of anger and normalizes it as part of being a human emotion. As others express their anger, it allows the individual to more easily express their own feelings about it, and provides for an experience of belonging and contributing.

DSM Criteria for ADD

The DSM-IV also provides diagnostic criteria for alcohol dependence. It views that physiological dependence on alcohol is indicated by evidence of tolerance or symptoms of withdrawal. Tolerance is the need for greatly increased amount of the substance to achieve intoxication or the desired effect. Withdrawal is said to be a maladaptive behavior change that happens when blood or tissue concentration of a substance decrease in individuals who have heavily used the substance. When experiencing these unpleasant withdrawal symptoms, people are likely to take the substance to relieve or avoid these unpleasant feelings. People suffering withdrawal typically use the substance throughout the day, beginning soon after awakening.
Adlerian View on Purpose of Alcohol Use

From an Adlerian view, alcohol use, especially in teens, can provide a virtually instantaneous feeling of belonging. Quite often, the only criteria in adolescent acceptance into a group is mutual selection of a drug of choice. The individual can be viewed as “good enough” by others merely by using the chemical. This is why it is imperative that the individual succeeds in finding other healthy venues for gaining a sense of belonging.

All behavior is purposeful. In addition to gaining acceptance into a group through chemical use, an individual may use it for the purpose of avoidance. It is imperative to help the individual identify what they may be avoiding. Many people use chemicals to avoid such issues as dealing with negative emotions like fear, anxiety, anger, loneliness, worthlessness, hopelessness, and feelings of inferiority and profound discouragement. Once the purpose of the behavior is identified, and the individual becomes aware of what they may be avoiding by using chemicals, they can address these issues and become encouraged to begin fulfilling or mastering their tasks of life in the areas of love, social, work, self and spirituality.

Prevalence of ADD

According to the DSM III-R (1987), most of the adults in the U.S. are light drinkers, 35% abstain, 55% drink fewer than 3 drinks per week, and 10% consume one or more ounces of alcohol per day. For male and female, the level of drinking is highest in the 21-34 year old age range. Two to five times more males than females are heavy drinkers, but different standards should be used between the sexes due to differences in
weight and body water. After the age of 65, abstainers exceed drinkers. Only 7% of males, and 2% of females in this age group are considered heavy drinkers. Ten percent of drinkers consume over half of the total of alcohol consumed. The DSM III-R notes three main patterns of alcohol abuse or dependency. The first looks at regular daily intake of large amounts. The second looks at heavy drinking, limited to weekends, and the third, long periods of sobriety are broken up with daily binge drinking lasting for weeks or months. The DSM III-R cautions that it is a mistake to associate one of the patterns exclusively with alcoholism. The DSM III-R identifies a species of alcoholism called “gamma alcoholism.” The central issue in gamma alcoholism surrounds control in that when a patient with gamma starts to drink, they are unable to stop until poor health or lack of money prevents drinking. The DSM III-R compares gamma with a type of alcoholism found in France. In this type, people with the alcoholism are not aware of a lack of control. They must drink a given amount of alcohol per day, but there is not compulsion to go beyond that amount. They will not recognize their alcohol problem until they stop drinking and develop withdrawal symptoms. The DSM III-R further states that although these two forms of alcoholism do exist, they don’t conform to the pattern of drinking seen in most people with alcohol abuse of dependence seen in the United States. This illustrates the need, when evaluating alcohol dependency, to consider cultural factors. Alcohol dependence and abuse is often associated with use and abuse of other drugs including cannabis, cocaine, heroine, amphetamines and sedatives. Frequent and simultaneous use of alcohol and these substances is commonly seen in teenagers and people under 30 years of age. Nicotine dependence is common. Contrary to some of the
studies cited in this paper, the DSM III-R states that depression appears to be a consequence of, and not a cause of, the drinking. In bi-polar disorder, drinking takes place more in the manic state, rather than the depressive state. Anxiety disorders, especially agoraphobia in female and social phobia in males occur in a large minority of people with alcohol abuse and dependence. These disorders often precede the heavy drinking, in attempts to self-medicate. The DSM III-R cites a community study done in the United States from 1981 to 1983 that indicated approximately 13% of the adult population have had alcohol abuse or dependence at some time in their life. Alcohol dependence will cluster within families. Adoption studies that have been completed have shown that cross-generational transmission of alcohol dependence does not require exposure to family member with alcohol problems. The implication of this is that alcoholism does appear to have a significant genetic component.

Sex Differences in Alcoholism

The course of alcoholism seems to differ between males and females. Male onset usually occurs in their 20’s with the males not being fully aware of dependence until their 30’s. Hospitalization usually occurs within this time period, and drop significantly in their 60’s and 70’s. The DSM III-R notes that in females, the onset and course of alcoholism is more variable. It tends to occur later in life and they tend to have a history of a mood disorder. The more people drink, they more they gradually need to drink to obtain the same mood altering effects. This is known as the concept of tolerance. A person with alcohol dependence can drink, at most, twice as much as someone who intermittently uses alcohol. People can vary widely in the amount of alcohol they tolerate.
The DSM III-R cites that some people are born with "in-born" tolerance. They appear to have been born with this capacity.

*Comorbidities of Anxiety and Depression in Alcoholism*

Driessen et al. (2001) studied the associations between anxiety and depression and treated alcoholics. They also identified the course of systems during early and late detoxification periods and studied the subject's behavior after discharge. They assessed 100 alcoholics using the Composite International Diagnostic Interview (CIDI). Three subgroups were studied. One group had comorbid depression and anxiety disorders. Another group had anxiety disorders only. The third group had no comorbid disorders. Anxiety and depression were assessed once per week and then again six months after discharge. Psychopathology decreased after the first four weeks of detoxification in all sub-groups. Anxiety remained at high levels in both the comorbid subgroups during the first four weeks. In the follow-up study, done six months after discharge, 60% of the non-comorbid subjects continued abstinence. Only 26% of all comorbid patients and 12% of those with comorbid depression and anxiety remained abstinent. The major finding is that when major anxiety and depression persists after three weeks of abstinence, the risk of relapse is great. A major implication of this study is the need to continue emotional support and assessment following treatment and periods of abstinence. This study also points out the importance in screening and diagnosing for depression and anxiety as part of a chemical intervention plan.
Future efforts could combine looking at the impact of psychotherapeutic interventions with medication interventions with alcoholics displaying current anxiety and depression.

**Effect of Depression on Remission/Relapse of Substance Dependence**

Hasin et al. (2002) studied the impact of depression on remission and relapse of substance dependence. They studied the effects of MDD under three circumstances. Onset of MDD prior to the onset of dependence, current MDD occurring during a period of abstinence, and current MDD during substance use that went beyond the expected impact of chemical use or withdrawal from chemical dependency. They studied 250 inpatients that had been diagnosed with MDD with DSM-IV criteria. These patients were also dependent on either cocaine, heroine or alcohol. Follow-up studies were done at 6, 12 and 18 months. Patients with current substance induced MDD were less likely to achieve sobriety than patients with no baseline MDD. A history of MDD prior to the onset of substance dependence reduced the likelihood of remission when compared to people with no such early onset. MDD during abstinence predicted relapse after discharge compared with those without MDD during abstinence. What this implies is that if it is determined that the patients has preexisting MDD prior to chemical abuse, it is imperative that both the MDD and the chemical abuse are treated. This is consistent with the aforementioned Driessen study (2001) which promoted the necessity of continued assessment for mood issues after structured treatment is completed.

Greenfield et al. (1998) performed a major study investigating the effect of depression on returning to drinking. They recruited 40 men and 61 women hospitalized
for alcohol dependence and tracked them for one year to study the impact of depression on drinking outcomes. They utilized structured interviews during the hospitalization and followed up with monthly interviews after discharge. They found that a diagnosis of current MDD at time of hospitalization was associated with shorter time to the first drink after treatment. No significant difference between men and women were found.

Interestingly, a commonly used depression inventory, call the Beck Depression Inventory, was utilized in this study. Depressive symptoms measured by the Beck Depression Inventory did not predict the time to first drink after treatment or relapse in women or men.

This study differs from other ones that have been done in that many have found that men and women do differ in the effect of depression on return to drinking. Greenfield cites several studies that have reported better outcomes for women with depression. One of these studies found that women with a lifetime diagnosis of MDD had better drinking outcomes one year after hospitalization than did women with co-occurring psychiatric diagnosis or alcohol dependence alone. Men with major depression had poorer drinking outcomes in the 3-year follow-up to this study. Gender difference disappeared and a lifetime diagnosis of MDD was coorelated with reduced drinking intensity for both men and women. In the subsequent 5-year follow-up, subjects with co-occurring MDD and alcohol dependence discovered that remission of MDD predicted remission of alcohol dependence, regardless of sex.
Greenfield attributes these sex differences to the idea that these study samples were small and the long-term between assessments may have effected client report due to poor recall or recall bias.

In summary, Greenfield’s results have major implications in this topic of study. Their results indicate that although symptoms of depression do not predict outcomes, that depression is associated more with rapid relapse for men and women. The results suggest that when MDD is diagnosed with adequate diagnostic criteria, they present a more critical issue than depressive symptoms that may be substance induced. It is critical to note that a diagnosis of major depression at the time of treatment strongly increases the probability of rapid relapse for both men and women.

*Relationship of Adolescent Depression on Alcohol and Drug Use*

Deykin et al. (1987) studies the relationship between adolescent depression, alcohol and drug use. They used an instrument call the Diagnostic Interview Schedule to assess MDD, alcohol and substance abuse with 424 college students. They discovered, using the DSM criteria, the amount of MDD was 7%, alcohol abuse was 8% and substance abuse was 9%. Alcohol abuse was associated with MDD, but not other psychiatric disorders.

A critical finding of this study was that the onset of MDD almost always came before alcohol or substance abuse. This leads to the conclusion that alcohol and other substances are a prime source of self-medication for this age group. In Adlerian terms, it is an example of chemical dependency being used as a compensation for profound discouragement. Subjects who reported a history of alcohol abuse were almost four times
as likely to have a history of MDD, as subjects who have not abused alcohol. In a more striking conclusion, it was discovered that females were as much as six times as likely to have experienced MDD if they are alcohol abusers.

Impact on Primary and Secondary Depression on Chemical Abuse

Deykin clearly states that distinctions need to be made between primary and secondary depression to clarify the relationship between depression and alcohol and drug abuse. He sees primary depression as depression occurring in a patient whose previous psychiatric history is negative or positive only for preexisting depression. Secondary depression is seen as a depressive episode in a patient who has a preexisting diagnosable psychiatric disorder. They identify the key to this classification being the chronology of the psychiatric disorder. In this study, 79% of alcohol and drug abusers had another primary psychiatric disorder prior to the alcohol and drug abuse. The implication of this study is the need for early identification and detection of mental health conditions in adolescent and college students. With the DSM III-R findings identifying that many people do not self-identify alcohol problems until in their 30’s, these findings point the need for personal and family education on the risk factors and warning signs involved in depression and substance abuse. Here these individuals have an entire decade of unawareness.

Windle et al. (1999) conducted a very comprehensive study of over one thousand adolescents that measured the correlation of various aspects of temperament, interpersonal relationships, stressful life events and other problem behavior with teenagers categorized into one of four groups: the no-problem group, depressed only
group, heavy drinking group, and mixed depression and heavy drinking group. In the no­
problem group, it was found that subjects had measures of healthier functioning on all
measures. The mixed group, depression and heavy drinking had the lowest functioning
level with elevations in childhood externalizing/acting out and stressful life events, low
levels of family support and high rates of delinquency and substance abuse. The
depressed only group identified internalizing patterns with childhood avoidance,
inflexibility and withdrawal being prominent. Heavy drinking only had high levels of
drinking by primary care givers and low levels of family cohesion. The initial sample in
this study had 975 high school students from three suburban high schools in New York.
In their discussion, Windle et al. (1999) believe that their results are consistent with
previous research. In the prevalence of depression, the ratio of 2.5 girls to 1 boy was
consistent with earlier gender studies. Boys had a higher rate of drinking at a 2:1 ratio.

Similar to the Deykin et al. (1987) study, which indicated that 23% of depressed
adolescence had a lifetime alcohol or substance abuse disorder, this study found between
24-27% meeting the criteria for depression in heavy drinking. The risk factors for
alcohol abuse and depression were clearly identified in this study. These results are
encouraging in that they point towards the potential success for prevention programs that
may focus on family education regarding encouraging healthy childhood experiences and
early identification over emotional issues rather than prevention programs for teenagers
that focus on single health problems because different adolescents have different risk
factors for different problems. The study limitations are that sample sizes are primarily
white, middle-class students which means generalizing the result to other populations
may be difficult. The study also relied extensively on self-report measures, additional raters and other assessments like behavioral observations would have increased the study’s value.

Adlerian View on the Importance of Early Positive Experiences

This study supports the Adlerian notion of the importance of positive early experiences in attempts to avoid mental health problems later in life. An individual’s view of themselves and how they relate to the world are shaped by the time they are 5 or 6 years old. Family education and early childhood programs continually stress the importance of a child’s early positive life experiences in giving them the encouragement they need to succeed later in life in mastering their life tasks.

Depression and Alcohol Consumption in College Population

Weitzman et al. (2004) studied the impact and relationship between depression and alcohol consumption in a national sample of college youth. A random sample of over 27,000 students was mailed to students at 120 colleges in the United States. In compiling results, they found that 4.8% of the students reported a condition labeled as Poor Mental Health/Depression (PMHD). The profiles of people who reported high degrees of PMHD were more likely to be female, non-white and from low socioeconomic families. This population was less likely to report never drinking and as likely to report frequent, heavy and heavy episodic drinking. This group was also more likely to report drinking to get drunk. This group, especially females, was more likely to report significant risk-taking activities while under the influence of alcohol.
Schuckit (1983) conducted a study of alcoholic patients living with and without secondary depression. He found that both groups were similar in demographics, early life anti-social problems, quantity and frequency of drinking and family history of affective disorders. Depressed patients had more alcoholism in first-degree male relatives and more alcohol life problems. The major difference between the groups was that depressed patients were heavier drug users of chemicals other than alcohol. The finding leads us to believe that depressed patients tend to use a wide variety of chemicals.

Effect of Alcohol Abstinence on Mood

The subjects in the study were 285 males that were diagnosed with alcoholism in a veterans administration medical center. One interesting finding in this study was that mood disturbances usually disappeared without antidepressants after two days to two weeks of abstinence. Schuckit believes that the sadness is more than a reaction to life stress. It includes the effect of alcohol on the brain. Since depression is also seen in “normal” subjects during experimental drinking situations, depressive symptoms in primary alcoholics who are actively drinking need to be taken seriously. This study cites that the lifetime risk for suicide in alcoholics approaches 10%.

Use of Alcohol in Managing Stress with Depression

Houlihan et al. (2003) studied 412 depressed patients and the extent to which they used drinking to cope with stress. The longitudinal study assessed these subjects four times over a ten year period. They found that patients that used drinking to help cope with life stress at the baseline posed a significant risk factor for more alcohol consumption at the 1, 4, and 10 year follow-up. More drinking problems were also
identified at the 1 and 4 year time periods. They hypothesized that self-medicating individual stress with alcohol strengthens the links between depression and drinking behaviors. The implications of this study points out the necessity for comprehensive alcohol use history as a part of any psychological evaluation.

Caldwell et al. (2002) studied the association between alcohol and depression/anxiety in young adults. They studied over 2,000 adults, ages 20-24 in a region of Australia. The study used a variety of measures including the Goldberg Depression and Anxiety Scales, The Positive and Negative Affect Schedule, and The Alcohol Use Disorders Identification Test. Findings include that men had low levels of positive mood and high levels of anxiety and depression with occasional and harmful consumption levels of alcohol. High levels of distress were also noted for male abstainers of alcohol. This distress was found to be related to being less extraverted and less physically healthy and not past substance abuse. For women, only hazardous drinking levels were found to have higher levels of depression and negative mood. As in other studies previously cited, harmful alcohol consumption was found to be related to use of marijuana, tobacco and recent life stressors.

*Depression in Alcohol Abstaining Populations*

Rodgers et al. (2000) replicated the Caldwell et al. (2002) results in finding depressive issues in the abstaining population. They used an instrument called the Alcohol Use Disorders Identification Test with two depression and anxiety symptom scales in a self-completion questionnaire. They sampled over 2,700 people in a general population from ages 18 to 80 years old. They found that alcohol use problems and
negative affect reports were reported at high levels in the abstaining population, as well as the heavy drinking population. Mild to moderate use reported significantly less of these mood related symptoms. Rodgers et al. (2000) asserts that this study is very significant in that it points out the need for more attention to be given to abstainers as a group at risk for mood and anxiety disorders. He did not exclude people with prior histories of alcohol dependence, as the purpose of the study was to reflect a general profile of the population. Rodgers also noted that these patterns did not apply to subjects over the age of 60. This points out the need to view these issues in age-related contexts to understand their interrelationship.

Lipton (1994) studied the effect of moderate alcohol use and it’s relation between stress and depression. Lipton’s results closely mirrored Caldwell’s (2002) results. In studying over 3,000 adults in the Los Angeles area in an interview format, they discovered that light and moderate drinkers had less depression in the presence of stress than people in extreme drinking categories. Abstainers and heavy users of alcohol reported significantly more depression than the light moderate/moderate drinking group. Lipton proposes in his study that alcohol can provide an effective “stress buffering” role in dealing with life events. He cautions that this study did not consider alcohol consumption to be a response to stress, but a typical element to a person’s lifestyle. Therefore, moderate drinkers may also do other things moderately, they live a more balanced lifestyle. Lipton suggests that various buffering models should be tested and in future research so that the precise relationship between stress, alcohol and depression can be studied. More detailed research could assess the level of other variable such as
personal coping skills or social support that are present in the light moderate/moderate drinkers in society.

*Relationship between Alcohol Withdrawal Effects and Depression*

Hasin et al. (2002) studied 6050 people who did not use drugs or smoke within the last year. These subjects were split into two different groups. One group met the criteria for DSM-IV alcohol dependence. The other group did not meet the criteria. Hasin, then compared these groups over a 12 month period for major depression. The purpose of the study was to investigate the theory that the association between alcoholism and major depression can be explained as misdiagnosed alcohol intoxication and withdrawal effects. In the study, Hasin et al. (2002) found that the existence of alcohol dependence raised the risk of current major depressive disorder by more than four times. Most of the subjects with major depression last used substances more than two years prior to the interview. This result seems to eliminate the possibility that intoxication withdrawal can explain the depressions. This study clearly highlights the importance of aggressively and systematically diagnosing depression in the chemically dependent population. Hasin’s results differed from the earlier Schuckit (1983) study, who also studied major depression in a large sample of alcoholic subjects. Schuckit found that the rate of major depression was actually lower among subject diagnosed with lifetime alcoholism. This may be due to several factors, especially the selection process of the subject studies. One noticeable difference were the assessment methods used. Schuckit diagnosed depression only if it occurred before the initial onset of alcoholism or appeared during a period of abstinence. This method assumed that any drinking after the diagnosis
of alcoholism would have been accompanied by intoxication or withdrawal effects to cause the major depressive symptoms. Schuckit included in this sample the relative of the alcoholics which made up about 65% of his sample. Because of this, it seems likely that most of these relatives were not treated for alcoholism, but it is possible that a number of them had some form of alcoholism that got better without treatment and was followed by normal years of drinking. Hasin states that this finding would be consistent with other studies that have identified the known differences between treated and untreated drinkers. Hasin asserts that major depression cannot be diagnosed during periods of normal drinking. If this occurred, rates of depression among these relatives would have been underestimated. This factor would reduce the rate of major depression in the group study.

*Genetic Influences on ADD and MDD*

Prescott et al. (2000) examined in a twins study the sex specific genetic influences on the relationship between alcoholism and major depression. They assessed MDD, alcohol abuse and alcohol dependence for both members of 3,755 twin pairs in the mid-Atlantic region of the United States. Results showed that individuals with MDD had a greatly increased risk for alcohol dependence and diagnosis of alcohol abuse and dependence. This significant increase was identified in both male pairs and female pairs but not among male or female fraternal twins. Prescott et al. (2000) asserts that this comorbidity exists due to the genetic and environmental sources of liability to MDD that overlap with underlying alcohol dependence. An interesting aspect of this study was that the underlying depression in women did not appear to come from the same factors
underlying alcoholism in men. Prescott theorizes that these differences can be explained if males are shaped by social factors to develop drinking problems rather than to express their depressive tendencies.

**Adlerian Perspective of MDD and ADD**

In Adlerian psychology, both depression and chemical dependency are the result of profound discouragement that individuals can feel, most likely beginning in infancy and continuing throughout their life. As a result, feelings of inferiority arise. Although genic components of depression and chemical dependency can be intergenerational, which can be determined by a family genogram, both are avoidance behavior. Since all behavior is purposeful, it is important to identify the goals of misbehavior. In avoidance behavior, it is a display of inadequacy where the mistaken belief is that they have no chance to succeed any other way and the goal is to have parents and other family members leave them alone to avoid further discouragement. Family therapy is crucial in this situation to help the family achieve ways to encourage each other.

**Methodological Considerations**

**Assessing Depression in Alcohol Dependency**

In this topic, two major considerations around issues of accurate diagnoses exists. Accurately assessing and diagnosing individuals with MDD and alcohol dependence disorder can be a very complicated process. Methodologically, it is difficult to assess the existence of depressive disorders while ruling out the impact of alcohol intoxication and withdrawal on these symptoms. This assessment process is critical in its implications for the treatment plan of individuals in this population. While using DSM-IV criteria is
prevalent and popular in these studies, it may not be the best fit for people in treatment for alcohol dependency.

*The AUDADIS Inventory*

The same issue existed to a similar extent in diagnosing alcohol dependency disorder. An extremely helpful instrument called the AUDADIS Inventory was standardized in the early 1990s and used in some of the studies that have been reviewed. The Alcohol Use Disorders and Associated Disabilities Schedule (AUDADIS) is a structured interview designed to evaluate alcohol use disorders, other drug use disorders, and psychiatric disorders. (Hasin, 1991).

The AUDADIS evaluates disorders according to DSM-III-R criteria, and, in its sections on alcohol use and other drug use, uses criteria of DSM-III and the DSM-IV. It was designed for use by survey interviewers, and was developed specifically for the National Longitudinal Alcohol Epidemiologic Survey, a large survey of alcohol disorders and related comorbidity, sponsored by the National Institute on Alcohol Abuse and Alcoholism. The AUDADIS also can be used in clinical settings. The AUDADIS assesses symptoms over a very broad range of severity. Alcohol-related questions in the AUDADIS can apply to community residents with mild disorders and to clinical patients whose disorders are more severe. In the study completed by Hasin et al. (1997) the instrument was shown to more accurately differentiate between alcohol abusers and those that were alcohol dependent. It is extremely helpful, in that it looks at behaviors and symptoms over the last 12 months and integrates DSM criteria for personality disorders and depressive disorders in the protocol. The AUDADIS can accurately identify the
chronology and interrelationship between disorders. Familial alcohol, chemical, and psychological issue are also assessed.

Use of Depression Assessments

When it comes to assessing depression in patients, a similar instrument does not exist for the chemically dependent population. Depressive disorders occur commonly in “primary care” patients. These are patients that are seen in medical facilities for a wide variety of concerns. Regrettably, primary care providers fail to diagnose many people that have depressive disorders. In an article that reviewed use of nine different instruments to assess depression, Mulrow et al. (2000) discovered that as many as 35-50% of patients were not diagnosed. As part of this study, Mulrow reviewed the validity of nine assessment tools to assess the level of depression in these clients. They reviewed usefulness of the Beck Depression Inventory, the Center for Epidemiologic Studies Depression Screen, The General Health Questionaire, The Hopkins System Checklist, The Medical Outcome Depression Screen, The Popoff Index of Depression, The Primary Care Evaluation of Mental Disorders, The Symptom Driven Diagnostic System and the Zung Self Assessment Depression Scale. All of these were found to be extremely useful to use in primary care settings and increased the number of people becoming accurately diagnosed with MDD. Interestingly, in comparing over 18 studies, no significant differences in diagnostic accuracy were found between instruments.

The presence of such a rating system for the chemically dependent population does not exist. This is crucial in that many studies highlight the controversy surrounding accurate diagnosis of depression in these populations. Many of the people in these
populations suffer from depressive symptoms brought on by chemical use or withdrawal. These depression rating scales previously discussed do not address this factor in the procedure. This points to the need for a more accurate screening process to determine whether or not MDD exists and needs to be treated in addition to the chemical dependency. Because no such instrument exists, any of the above instruments should continue to be used to assess depression levels (i.e., Beck Depression Inventory) as part of the treatment process.

*Research Limitations in Chemically Dependent Populations*

One methodological issue is that it is difficult to conduct completely controlled studies in this area in that you would have to withhold treatment from significant portions of this population to truly measure the impact of intervention, which may be unethical. Also, studies such as this, are based on client self-report of mood and, most importantly, levels of use. Analyzing longer remissions would also be extremely beneficial because it would add even more legitimacy to the accuracy of this study.

*Clinical Implications*

*Depression Screenings in Alcohol Populations*

MDD needs to be actively and rigorously screened in the alcoholic population for purposes of effective treatment. Untreated MDD can lead to early relapse and self-medication. Obtaining a comprehensive individual/family history is necessary to note the preexistence of MDD in alcoholics. Significant family members and relationships should be included to identify potential symptoms of MDD and possible genetic predispositions. (Greenfield et al. (1998); Driessen et al. (2001); Hasin et al. (2002); Prescott et al. (2000).
Sex Differences in Assessment

Sex differences exist in symptom presentation around depression and chemical issues during treatment. Women tend to report depressive symptoms at a greater degree than men. Men tend to report chemical problems at a higher rate than women. Using this awareness, treatment procedures need to actively get feedback from a wide variety of sources to ensure that accurate symptom exists. (Greenfield et al. (1998); Prescott et al. (2000); Caldwell et al. (2002).

Early Detection and Prevention

Early detection and prevention of symptoms/behaviors that precede MDD and alcohol dependence is possible. Studies have identified behaviors that lead to these disorders. Early intervention and detection around these behaviors will potentially dramatically reduce problems in both disorders. Genetic factors in these disorders are very significant. (Deykin et al. (1987); Windle et al (1999); Prescott et al. (2000).

Support Groups for Dual Diagnosis of MDD and ADD

Support groups for individuals in recovery need to adequately address and support treatment for individuals that have the dual-diagnosis of MDD and ADD.

One of the controversies surrounding treatment of individuals revolves around the role of Alcoholics Anonymous (AA) and it’s perspective that recovery from substance dependence should be primarily in the spiritual/emotional areas. Participants in AA frequently report that as part of their recovery plan they are often discouraged or prohibited from using anti-depression medication as part of their treatment. With many AA participants reporting this experience, this controversy prompted AA to produce a
variety of brochures that state their position that anti-depressant medication can be an appropriate part of treatment. In a brochure entitled “The AA member – Medication and Other Drugs (1984), a group of physicians in AA supported the use of members taking prescribed medications to treat certain medical problems such as depression. They assert that, while it’s wrong to support the re-addiction of any alcoholic to any drug, it is equally wrong to deprive them of medications that control other disabling physical and emotional problems. Although AA has produced this brochure, individuals report that common practice within AA meetings is often to discourage the use of anti-depressants.

This controversy over treatment has spawned the existence of other support groups, such as Dual Recovery Anonymous (DRA). Their primary mission is to prevent relapse while acknowledging the need to actively treat the comorbid conditions inherent in addition. They combine the traditional 12-step model while encouraging aggressive treatment of disorders such as anxiety, depression and other psychological conditions.

An Adlerian Approach to Transferring Dependencies

Individuals who are dependent on chemicals typically have dependent personalities. It is imperative that once they are no longer dependent on their drug of choice, that this dependency be channeled into areas that can be productive and lead to healthy feelings of social interest. This is especially important because social interest is the barometer of mental health, and the individual needs to find ways to belong and contribute in order to sustain their mental health. A productive way to do this would be to help the individual find something that they are equally as passionate about, as they were the chemical, and then find others who share this interest.
Limitations of Studies Applications

Sampling Procedures

It is difficult to generalize the results of some of the studies reviewed due to the wide range of sampling procedures used in these studies. It is difficult to find diverse populations within which to do this research. Some studies used phone interview procedures with the general population to gather a wide range that would reflect the general population. Out of necessity, other studies needed to utilize hospital/treatment centers to obtain significant sizes of chemically dependent individuals to complete these studies. Other studies were done exclusively with college students. The limitation of these samples may have potentially skewed results due to the fact that the demographic of a college student is significantly different from general populations. Clients in hospitals and treatment centers could potentially differ in the severity of their symptoms and motivation to change. In general population studies, it is more difficult to obtain personal data in that they are based on voluntary self-report. (Houlihan et al. (2003); Greenfield et al. (1998); Driesen et al. (2001); Hasin et al. (2000); Lipton (1994); Caldwell et al., (2002); Windle et al. (1999); Prescott et al. (2000); Schuckit (1983); Deykin et al (1987).

Future Research

Assessment Tools for Depression in Chemical Dependency

While the diagnosis of ADD has taken great strides with the instrument called the AUDADIS, similar instruments to accurately measure depression within the chemically dependent population do not exist. Comprehensive procedures that rely on sources
beyond client self-report are needed to more clearly differentiate between the effects of MDD and drug intoxication/withdrawal effects.

*Simultaneous Treatment of MDD and ADD*

Research around the effectiveness of treating MDD simultaneously with ADD would be very useful. Studies that have investigated the success/risks of this approach were very difficult to find. Along with this concern, it would be important to note the degree of self-medication for depression that occurs when people are prevented from using anti-depressant medication during the course of treatment.

*Comparing Medication and Cognitive Behavior Therapy*

It would be useful to compare the impact of medication treated depression with a cognitive-behavior therapy approach within the alcohol dependent population. If cognitive–behavior therapy were found to be effective in treatment, it could be combined with medication for improved results or act as a stand-alone treatment for high-risk users.

*Long-Term Effects of Treating MDD and ADD*

It would be critical to conduct longitudinal research studies on the outcomes of people who had dual diagnosis of MDD and ADD and studied within two groups, those who were treated and those who were not treated for MDD.

**Conclusion**

It is a concern that most healthcare providers do not conduct current research reviews in the interrelationship of MDD and ADD. As a result, many clients are underserved due to the fact that many providers use procedures that do not treat MDD until a significant period of abstinence from alcohol. The result of this research review is that it
is apparent that effective treatment of MDD can prevent problems with substance abuse among the general population and reduce the likelihood of relapse within the alcohol dependency population. Based on the findings within this research, it would seem that the professional and ethical choice is to remain current on this research and apply the recommendations when treating clients. This would mean automatically testing for MDD in those individuals who present with the potential comorbidity of MDD and ADD and treating accordingly. In an Adlerian view, this would include assessing and treating the MDD through therapeutic techniques. If further intervention is needed, medication could be a consideration to use in conjunction with therapy.
References


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