Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery

Introduction

This course is designed to assist those professionals who are working with Substance Abuse Clients who are experiencing depressive symptoms. These symptoms are common among clients in substance abuse treatment. Some studies indicate that as many as 98% of those presenting for substance abuse treatment have some symptoms of depression. Even when these symptoms do not reach the level of formal DSM-V diagnosis, they represent a serious impediment to effective treatment and an increased risk of relapse if not addressed. Topics covered include: the nature of depressive symptoms, how depressive symptoms affect treatment efforts, range of clients who may experience depressive symptoms, approaches that may prove effective with this population, special setting specific considerations, and the professional roles and responsibilities of the substance abuse professional in relation to clients with depressive symptoms. The author was a contributor to a SAMHSA Treatment Improvement Protocol or TIP which deals with much of the content of this course.

Upon taking this course, the intent is that the course taker shall be more effective in recognizing the signs of depression, be better at planning for the treatment of those who suffer from depressive symptoms

Depressive symptoms are common among those individuals with a diagnosis of chemical dependence in need of substance abuse treatment. Many studies indicate that the number of people with substance abuse diagnoses who also suffer from depressive symptoms is very high: perhaps as high as 98%. This is not terribly surprising in light of several historical and situational variables the substance abuse client's life. First; substance abusing clients more often than not arrive for treatment as a result of some crisis related to their use. These clients see these crises as self inflicted or imposed on them by inconsiderate or thoughtless others. If they see the crisis as self inflicted they may well experience shame, guilt, remorse regret, or self doubt as a result. If they see the crisis as imposed or triggered by others they may be experiencing a range of conditions including; frustration, anger and helplessness. Imagine the awful experience

of having to confront (in a sober state) the wreckage they have made of their health, career, relationships, etc. Surely this realization is depressing, and many of our clients experience it that way. Second: they predictably experience Acute Withdrawal and what has been called Post Acute Withdrawal. Upon cessation of use of a chemical of abuse, numerous studies suggest that the client suffers from an acute stage of withdrawal which is frequently marked by dramatic physical and mental symptoms including: anxiety, depression, shakes, sweats, elevated or depressed vital signs (e.g. pulse, temperature, blood pressure, etc), seizures, sleep disturbance, …….. These withdrawal syndromes are well documented and understood. Each drug of abuse has a well documented acute withdrawal syndrome and well understood best practice for treating it. Less well understood (but well documented) is the form of withdrawal which follows the acute phase. It has been called Post Acute Withdrawal. It results from long time abuse to the human organism, durable and sometimes permanent change to the individual neurological structures and chemistry, and durable patterns of learned behaviors and reactivity. The chemical of abuse has been an organizing principle in the individual's life for so long, that the entire organism (mind, body and spirit) has made progressive and successive adaptations to it. They have normalized the abnormal and self destructive experience for so long that they have forgotten what normal is.

In short, for a period of time that varies with each chemical and each individual, the recovering person feels a range of baffling feelings, is learning what normal Is and how to do it, has sleep disturbances, and a range of other things which are often found on classic depression symptom lists.

- According to some studies, some problems with depressive symptoms can linger for 3 to 6 months after abstinence. Other studies suggest these symptoms can last for up to a year to 18 months.
- Even though depressive symptoms may be related to substance use or withdrawal, they still must be addressed in counseling.
- The issue of whether the depression is an artifact of or pre-existing to the substance abuse is irrelevant to treatment in early recovery

.

A Clinical Axiom

Appropriate treatment for depressive symptoms has been shown to improve substance abuse treatment outcomes. Therefore, addressing depressive symptoms must be a concern to the professional providing substance abuse treatment. Further, substance abuse and depressive symptoms are more successfully dealt with when dealt with concurrently.

What does depression look like?

Many have sought to describe depression and depressive symptoms. Of all the human mental ailments, depression is, perhaps the best studied, described and understood. For nearly 2 centuries, depression has been studied and described and there have been a number of descriptive lists produced. All these lists have core symptoms in common. Below is a list that reflects these common symptoms. Each is accompanied by a brief description and/or example.

One such list follows:

- Loss of interest in most activities: This aspect of depression is quite common with our chemical dependency clients. It is often seen as a reduction in the range of normal or usual activities or interests in lieu of addiction centered/driven interests or activities. Upon recovery many report feeling/believing that their options or experiences are limited or that they feel existentially hollow. The genesis of this aspect may well be the pattern generated by the addiction or could predate the chemical dependency. In either eventuality, this needs to be addressed when it is part of the clinical picture of the recovering person.

- Significant change in weight or appetite: It is important to remember that this symptom can be reflected as an unusual increase or decrease in weight. Lack of appetite of depression or dramatically increased appetite are both equally likely symptoms

- Sleep disturbances: This symptom can be exhibited in one or more of four ways. There can be too much sleep, there can be too little sleep or sleeplessness, sleep can come improperly timed (can't sleep at customary bed time; can't stay awake during wake times), or sleep is very unproductive (not restful). There is

some discussion as to whether this sleep disturbance is a result of the well documented rebound effect of addiction or is a function of free standing depression. Whatever the genesis, this symptom leaves the recovering client vulnerable to relapse and needs to be addressed when present.

- Difficulty in concentration: Early on in recovery our clients will report not being able to focus oo concentrate on something (including treatment) for any length of time. They report not being able to get much from psycho-education lectures or state that they are just now hearing something to which they have been exposed a number of times before.

- Decreased energy, chronic fatigue, or tiredness This symptom is self explanatory. Clients experiencing this symptom will use a variety of terms to describe their lack of energy such as; “too pooped to pop” or “exhausted all the time”. Often this is the reason and/or excuse for missing self help or therapy sessions.

- Feelings of guilt: Guilt in and of itself is not a symptom of depression. In fact, guilt is a necessary to survival, first order feeling. (Mock, 2015) Clients will nearly always feel guilt about some of the regrettable even unconscionable behaviors they engaged in when in the midst of their addiction. When guilt is a symptom of depression, is when it is more generalized or doesn’t have a reasonable object. For example they feel guilt about nothing definable or about everything or about things not under their sphere of influence. Sometimes this misplaced guilt is turned back on themselves and becomes shame. Shame is guilt not for what I have done but for what I am. Shame of this sort can be so diminishing it can get in the way of movement toward a healthier self.

- Feelings of low self-esteem, low self-confidence, or worthlessness: We find that this symptom is expressed by clients when they reflect on the number of times they have tried to quit unsuccessfully, how unsuccessful they have been in other endeavors while using their drug of choice. In this way this symptom might be either an artifact of the addiction experience or it may be a symptom of co-resident, independent depression. Whichever is true, it effects our clients in the same way and represents a risk to sobriety.

- Feelings of pessimism, despair, or hopelessness: This one is also fairly self explanatory. The paragraph above could apply equally to this symptom.

- Social withdrawal: This is perhaps the most commonly reported symptom by individuals in early recovery. The question is does this come from co-resident, perhaps pre-existing depression, an artifact of addiction, or some of both? After all, their use of chemicals was often solitary and was so for years. This

habituated social pattern may be nearly as hard to break as the drug habit. It is nearly a cliché in treatment circles that people don't acquire sobriety alone or in asocial vacuum..

- Frequently agitated, restless: This is a very frequent symptom in individuals with depressive symptoms in early recovery. It may be the most common symptom seen in the early recovery. Many professionals in the field of chemical dependency can relate to this group of clients exhibiting what we commonly call agitated depression.

- More frequently withdrawn, reclusive, prefers being alone: This symptom will oftentimes be expressed as unwillingness or personally perceived ability to go to self help meetings, psycho education or other treatment. With so many years spent with their drug serving as a social lubricant, they may now find themselves out of practice in essential social skills.

- Feelings of irritability or excessive anger: Whatever the genesis of this symptom, we clinicians often hear of it from family members and others in close proximity to the client. AA and other self help literature speaks of this symptom as being possible during early recovery. This is probably true because this symptom is as common with anxiety and depression. Research indicates that clients in early recovery suffer from one or both of these co-existing conditions.

- Decrease in activity, effectiveness, or productivity: It seems almost paradoxical that our clients should cease using drugs or alcohol and suffer this kind of decline. However, research observations have documented this phenomenon for at least 60 years. This is most commonly spoken to in the Employee Assistance Program literature.

- Difficulty in thinking, reflected by poor concentration, poor memory, or indecisiveness. This is relatively self explanatory. Clients often relate that they fear their substance abuse has permanently damaged them mentally.

- Excessive or inappropriate worries: This set of symptoms can take unusual, occasionally bizarre, forms. The worries can be so intense as to be stultifying. Clients often report being worried about things that are beyond their current or historical sphere of influence.

- Being easily moved to tears: This is expressed when clients report crying about things that haven't previously driven them to tears. They will also report being baffled and feeling apologetic about their teary reaction to an unusual or relatively benign thing.

- Anticipating the worst and hyper vigilance: A long recent negative addiction related history has led the client to properly anticipate that the world may in fact hold a succession of bad events.
- Hopelessness and Thoughts of suicide: This is one of the most compelling reasons for screening for depression and depressive symptoms in recovery. Clients report that this set of feelings and thoughts leads them to believe that a return to drinking/drugging may seem a less onerous alternative to being this way.

Screening and Assessment

Some Depression Scales Worth Considering

Hamilton Depression Rating Scale

The **Hamilton Depression Rating Scale** (HAM-D) is a 21-question multiple choice questionnaire which doctors may use to rate the severity of a patient's depression. It was originally published in 1960 by Max Hamilton, and is presently one of the most commonly used scales for rating depression in medical research. The questionnaire rates the severity of symptoms observed in depression such as low mood, insomnia, agitation, anxiety and weight-loss.

The doctor must choose the possible responses to each question by interviewing the patient and observing their symptoms. Each question has between 3-5 possible responses which increase in severity. The first 17 questions contribute to the total score and questions 18-21 are recorded to give further information about the depression such as if paranoid symptoms are present.

Hamilton, M (1960) A rating scale for depression. *Journal of Neurology, Neurosurgery and Psychiatry.* **23**: 56-62

Beck Depression Inventory

The **Beck Depression Inventory** (**BDI**, **BDI-II**), created by Dr. Aaron T. Beck, is a 21-question multiple-choice self-report inventory that is one of the most widely used instruments for measuring the severity of depression. The most current version of the questionnaire is designed for individuals aged 13 and over and is composed of items relating to depression symptoms such as hopelessness and irritability, cognitions such as guilt or feelings of being punished, as well as physical symptoms such as fatigue, weight loss, and lack of interest in sex.[1] There are three versions of the BDI—the original BDI, first published in 1961 and later revised in 1971 as the BDI-1A, and the BDI-II, published in 1996. The BDI is widely used as an assessment tool by healthcare professionals and researchers in a variety of settings.

Beck A.T. (1988). "Beck Hopelessness Scale." *The Psychological Corporation*.

Beck A.T., Ward C., Mendelson M. (1961). "Beck Depression Inventory (BDI)". *Arch Gen Psychiatry* **4**: 561-571.

Zung Self-Rating Depression Scale

The **Zung Self-Rating Depression Scale** was designed by Duke University psychiatrist, Dr. William W.K. Zung to assess the level of depression for patients diagnosed with depressive disorder.

The Zung Self-Rating Depression Scale is a short self-administered survey to quantify the depressed status of a patient. There are 20 items on the scale that rate the four common characteristics of depression: the pervasive effect, the physiological equivalents, other disturbances, and psychomotor activities.

There are ten positively worded and ten negatively worded questions. Each question is scored on a scale of 1-4 (a little of the time, some of the time, good part of the time, most of the time).

The scores range from 25-100.

25-49 Normal Range

50-59 Mildly Depressed

60-69 Moderately Depressed

70 and above Severely Depressed

Zung, WWK (1965) A self-rating depression scale. Arch Gen Psychiatry 12, 63-70.

Center for Epidemiologic Studies Depression Scales (CES-D)

N.B. In addition to the psychometrically rigorous instruments above, there is an additional instrument listed in the Treatment Improvement Protocol 48. It is not an empirically tested screening instrument like the previous three. The 20 questions in it are very similar to those found in the other three, but it has not been empirically tested as a screening instrument. Rather than being used for a screening/diagnostic instrument, it is well suited to be used for client monitoring in a clinical setting. The suggestion is to administer the instrument at the beginning of treatment and then periodically throughout the course of treatment. In this way, changes in mood may be caught more quickly. The CES-D seems to be very robust and appears to have good test-retest strength. (A copy with scoring key has been included in Appendix A)

A Clinical Axiom

There is a high probability that substance abuse clients will exhibit depressive symptoms and depressive symptoms which will impede treatment efforts. Therefore, depression screening should be a routine element of substance abuse treatment

The Reality of the Client with Depressive Symptoms

As noted in Managing Depressive Symptoms: A Review of the Literature, Part 3 (www.kap.samhsa.gov),

Persons with depressive symptoms tend to take a negative view of themselves, their surroundings, and their relationships and lack hope that things will get better. The following examples of typical depressive thinking styles (adapted from Gilbert, 2000) provide insight into the experience of depression:

• *Jumping to conclusions*—Depressed people tend to jump to conclusions easily, particularly negative conclusions. For example, John's friend is in an irritable mood so he concludes this is because he has offended her.

• *Emotional reasoning*—Emotional reasoning is related to jumping to conclusions. Depressed people may assume that their emotions give them an accurate view of the world and do not test further. In the above example, John may not ask his friend whether he has done anything to offend her. He simply assumes his "gut reaction" is accurate.

• *Discounting the positive*—Depressed people tend to discount their positives. They are not able to focus on things they do have, only those that they don't have. As a result, they may feel deprived or disappointed. Even when people who are depressed achieve something, they tend to discount it with the idea that "anyone could do that."

• *Disbelieving others*—It is very common for depressed people to believe that others are being nice only because they want to appear good themselves. Depressed people often believe that individuals have one set of thoughts they express outwardly and a set of thoughts they keep private. They worry that the private thoughts of people are very negative toward them.

• *Black and white thinking*—Depression makes it harder to think about life in complex ways. Thinking tends to become black and white and "either/or." Either one is a success or a failure; either this relationship is good or it is a complete failure.

•*Selective comparison*--- This is the process whereby the client compares self to everyone in their experience in a way which leaves them feeling inadequate in the extreme. They identify the best trait, quality or attribute of an individual and compare that to that trait, quality or attribute in self. In this way they are almost certain to fall short. This process is in addition to the tendency to self devaluate. Rather it reinforces it by having the client make multiple comparisons on which they fall short. This gives them an aggregate picture of self composed of predominantly negative comparisons.

When combined with the sadness, inability to derive pleasure from life, and feelings of isolation that are characteristic of depression, these thinking patterns can lead to a dark and hopeless view of the world. To effectively work with a client with depressive symptoms, you will need to enter that world with as much understanding and empathy as possible. Only then can you guide the client in ways that will assist him or her in emerging from the depressive symptoms and open the way to recovery from addiction. Gentle but effective reality testing and therapeutic confrontation are essential to combat this real world depressive reality.

Clinical Axiom

Because of the likely hood of depression or at least depressive symptoms, all clients in substance abuse treatment should be screened for suicidality

Sadness or Depression

depression is ongoing, sadness is time limited

sadness is bound to something, depressive symptoms are not bound/ They are attached to “nothing and everything”

What kind of barrier to treatment does this depression represent?

- Clients have difficulty in concentrating and so absorb clinically helpful information available to them through treatment, psycho-education and self-help.
- Trouble keeping appointments. Simple: they can’t get benefit from even the most miraculously effective treatment interventions if not exposed to them. This applies to treatment efforts and to their positive exposure to self help groups such as AA.
- Lack of energy to participate or lack of interest in substance abuse treatment program activities
- Lack of perceived ability or lack of motivation to change.
- Belief that he or she is beyond help.
- Being overwhelmed by feelings

- Terminal “uniqueness” is a condition most of our clients experience. It is a belief that nobody has suffered or experienced as deeply or traumatically as they….ever.

What is the job?

- Psycho-education
- Integration of tx for depression and CD
- Understanding depression
- Negative thought reframing
- Reality testing
- Coaching for behavior change
- Developing coping skills
- Emotional Management skills
- Support and motivation enhancement

Approaches and Interventions for Dealing with Depressive Symptoms

The literature reports evidence that some psychological therapies (e.g., cognitive–behavioral therapies, psycho-education) and some drug therapies are effective in relieving depressive symptoms. From a practical perspective, you should keep in mind the point made earlier that depressive symptoms exist on a spectrum. The difference between having depressive symptoms and having a clinical depression can be the presence or absence of a single symptom or the degree to which a specific symptom limits a person’s ability to function. There is also no current evidence that the causes of depressive symptoms differ from those of major depression or dysthymia.
Until further research is available, it is sensible to assume that those interventions and counseling approaches that work for major depression or dysthymia will likely be of help to persons with depressive symptoms.

• **Cognitive–behavioral therapy (CBT)—**CBT integrates principles derived from both cognitive and behavioral theories. It adds to behavioral theory the idea that cognitions

(or thoughts) mediate between situational demands and an individual's attempts to respond to them effectively. It adds to cognitive therapy the idea that changing behavior can be a powerful influence both on the acceptance of changes in cognitions about self or a situation and on the establishment of a newly learned pattern of cognitive–behavioral interactions. In practice, CBT makes use of a wider range of coping strategies, not all of which are cognitive in nature (e.g., having individuals change behaviors directly rather than focusing on change in thinking).

• **Supportive/expressive (affectively based) therapies**—Supportive/expressive therapies focus on supporting clients in experiencing and modulating feelings that have heretofore been disavowed or distorted. The goal of supportive/expressive therapy is to have feelings be a productive rather than limiting component of recovery.

• **Motivational interviewing**—The goal of motivational interviewing and related motivational strategies is to assist clients in mobilizing, seeking, and benefiting from a variety of change approaches, as well as to sustain the energy required to achieve lasting change.

• **Behavioral interventions**—Behavioral interventions focus on helping clients change problematic behaviors or take on new behaviors that will benefit and sustain recovery. Behavioral interventions assume that as an individual changes behavior, more productive thinking and feelings will follow.

Choosing Among Interventions—There is no cookbook that will tell you which intervention approaches to use with a given client at a given point in his or her recovery. Rather, the interventions described above constitute a "toolkit" on which you can draw. Different substance abuse treatment and mental, health counselors emphasize different interventions and approaches depending on their own skills, preferences, and counseling styles. If you are not comfortable with a given intervention, it is not likely to help your client. Thus, it may be best initially to use a limited number of techniques and expand your toolkit as experience and confidence grows.

Clinical Axiom

Treatment of individuals with substance abuse and depressive symptoms is best provided in an integrated care model setting. It should be individualized to meet the client's needs.

Evidence-Based Thinking—Some counselors may find it useful to think of their work in terms of what has been called “evidence-based thinking” (Hyde, Falls, Morris, & Schoenwald, 2003). Evidence-based thinking means picking the best clinical option available for a given client in a given context based on the best current information. The information that is used in evidence-based thinking includes

- Research and the experience and recommendations of clinical experts
- Your past experience
- Your personal preferences and style
- Advice from your clinical supervisor
- The needs, values, preferences, and characteristics of the client
- Constraints such as the number of sessions you have available

Evidence-based thinking mixes science and clinical experience with a large measure of common sense. The counselor who uses evidence-based thinking is flexible, always looking out for changes in the client’s needs, and constantly adjusting their approach to make use of new information.

However, all these interventions seek to break the cycle of maladaptive thoughts, beliefs, behaviors, and emotional reactions that are characteristic of depression

Treatment Models: Sequential, Parallel, Or Integrated

As the mental health and AOD abuse treatment fields have become increasingly aware of the existence of patients with dual disorders, various attempts have been made to adapt treatment to the special needs of these patients (Baker, 1991; Lehman et al., 1989; Minkoff, 1989; Minkoff and Drake, 1991; Ries, 1993a). These attempts have reflected philosophical differences about the nature of dual disorders, as well as differing opinions regarding the best way to treat them. These attempts also reflect the limitations of available resources, as well as differences in treatment responses for different types and severities of dual disorders. Three approaches have been taken to treatment.

Treatment Models
• Sequential: The patient participates in one system, then the other. • Parallel: The patient participates in two systems simultaneously. • Integrated: The patient participates in a single unified and comprehensive treatment program for dual disorders.

Sequential Treatment

The first and historically most common model of dual disorder treatment is sequential treatment. In this model of treatment, the patient is treated by one system (addiction or mental health) and then by the other. Indeed, some clinicians believe that addiction treatment must always be initiated first, and that the individual must be in a stage of abstinent recovery from addiction before treatment for the psychiatric disorder can begin. On the other hand, other clinicians believe that treatment for the psychiatric disorder should begin prior to the initiation of abstinence and addiction treatment. Still other clinicians believe that symptom severity at the time of entry to treatment should dictate whether the individual is treated in a mental health setting or an addiction treatment setting or that the disorder that emerged first should be treated first.

The term *sequential treatment* describes the serial or nonsimultaneous participation in both mental health and addiction treatment settings. For example, a person with dual disorders may receive treatment at a community mental health center program during occasional periods of depression and attend a local AOD treatment program following infrequent alcoholic binges. Systems that have developed serial treatment approaches generally incorporate one of the above orientations toward the treatment of patients with dual disorders.

Parallel Treatment

A related approach involves *parallel treatment:*the simultaneous involvement of the patient in both mental health and addiction treatment settings. For example, an individual may participate in AOD education and drug refusal classes at an addiction treatment program, participate in a 12-step group such as AA, and attend group therapy and medication education classes at a mental health center. Both parallel and sequential treatment involve the utilization of existing treatment programs and settings. Thus, mental health treatment is provided by mental health clinicians, and addiction treatment is provided by addiction treatment clinicians. Coordination between settings is quite variable.

Integrated Treatment

A third model, called *integrated treatment,* is an approach that combines elements of both mental health and addiction treatment into a unified and comprehensive treatment program for patients with dual disorders. Ideally, integrated treatment involves clinicians cross-trained in both mental health and addiction, as well as a unified case management approach, making it possible to monitor and treat patients through various psychiatric and AOD crises.

There are advantages and disadvantages in sequential, parallel, and integrated treatment approaches. Differences in dual disorder combinations, symptom severity,

and degree of impairment greatly affect the appropriateness of a treatment model for a specific individual. For example, sequential and parallel treatment may be most appropriate for patients who have a very severe problem with one disorder, but a mild problem with the other. However, patients with dual disorders who obtain treatment from two separate systems frequently receive conflicting therapeutic messages; in addition, financial coverage and even confidentiality laws vary between the two systems.

In contrast, integrated treatment places the burden of treatment continuity on a case manager who is expert in both psychiatric and AOD use disorders. Further, integrated treatment involves simultaneous treatment of both disorders in a setting designed to accommodate both problems.

Mood Disorders
Introduction

In the history of the treatment of substance abuse in this country, it has been axiomatic that recovery occurs best, most assuredly when the client is also actively engaged in a 12-step program of recovery and other "social therapies." The clinical and research literature suggests that clients with co-occurring mental health and substance abuse disorders have difficulty accessing the sources of care that would be most effective for them including and especially 12-step programs. Each major mental health diagnostic category; mood disorders, anxiety disorders, personality disorders and psychotic disorders, represents a characteristic set of barriers to 12-step involvement. This workshop examines those barriers and explores methods for helping this client population to connect with and utilize 12-step help.

Benefits of involvement in a 12-step program

- **Ready regeneration of a natural, organic network**
- **Intrusive nature of some members makes isolating harder**
- **Early recovery high is good bridge to more durable change**
- **Good place to invest excess energy**

- **Pacing through artificial controls of tradition and cliché**

Impediments to accessing a 12-step program

- **Tendency to isolate when they most need not to**
- **Occasional resistance to medication regimen by well meaning members**
- **Content of meetings may serve as craving cues**
- **Being high maintenance they can wear out fellow members**
- **High tendency to relapse discourages sponsors and others in the program**
- **Craving Cues" are more complicated than for others**
- **Personality disorder like behaviors**

Interventions that facilitate the use of 12-step programs

- **Promote "old-timer" sponsor network**
- **Establish regular meeting schedule with home group and "home away from home" groups**
- **Good mix of meetings with early emphasis on discussion meetings**
- **Beginner meetings to help build a recovery cohort**
- **Find "double trouble" meetings where there is an over representation of co-occurring disordered members**