Co-Occurring Chronic Depression and Alcohol Dependence: A Novel Treatment Approach

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Abstract

Objectives: Research suggests a lack of successful treatment options targeted specifically for chronically depressed alcohol-dependent individuals. This may be due, in part, to the complex characteristics these individuals possess that make their treatment more challenging. There are currently several empirically supported behavioral treatments for depression and alcoholism as individual disorders; however, few interventions have shown consistent results for treating these disorders concurrently. Cognitive Behavioral Analysis System of Psychotherapy (CBASP) has demonstrated effectiveness in treating chronic depression, but has not yet been studied in persons with co-occurring alcohol dependence and chronic depression. We examine the feasibility of utilizing CBASP in 2 individuals who have co-occurring chronic depression and alcohol dependence, and explore its impact upon depression and alcohol intake.

Methods: We conducted 2 case studies and implemented 20 weeks of manualized CBASP adapted for use in alcohol-dependent individuals.

Results: Both participants tolerated the therapy well and completed the study. CBASP was effective in reducing symptoms of chronic depression and significantly reducing alcohol intake to healthy drinking levels.

Conclusions: CBASP seems to be ideally suited for this population, which has extensive avoidance learning, high rates of early trauma, repeated interpersonal failures, and uses alcohol to cope. We propose that treatment for this population must be tailored to the underlying interpersonal issues and skill deficits described above in order to be effective, and that CBASP can be the therapy for the chronically depressed, alcohol-dependent individual.

Key Words: alcohol dependence, chronic depression, CBASP, behavioral treatment

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Major depression and alcohol dependence are 2 of the most prevalent psychiatric disorders affecting the general population, resulting in significant consequences to society at large, including lost productivity, health care demands, psychosocial disruption, and even increased mortality rates.1 Recent research suggests that excessive alcohol use and depression account for an estimated $223.5 billion and $83.1 billion, respectively, in economic costs to the United States alone.2,3 In addition, prevalence rates of comorbidity between alcohol dependence and depression are rising; 12-month prevalence rates of alcohol dependence among individuals with a 12-month, Diagnostic and Statistical Manual of Mental Disorders, 4th ed, Text Revision,4 diagnosis of major depression and dysthymia were 11.03% and 9.62%, respectively.5 As a result of the deleterious psychological impact on the individual and the economic burden on society, there is a growing interest in increasing understanding of the co-occurrence of alcohol dependence and major depression, and development and implementation of effective treatments for these significant and prevalent disorders.

Multiple empirically supported behavioral treatments exist to treat chronic depression and alcohol dependence separately, but there is less research examining concomitant or integrated treatment for co-occurring chronic depression and alcohol dependence. Although there has been a modicum of research regarding the etiology, relationships, and treatment of chronic depression and alcoholism, the specific common mechanisms and effective treatments have been elusive. Of note, the majority of so-called “third wave” cognitive behavioral therapies
have not yet been rigorously studied for this specific population of chronically depressed alcohol-dependent (CDAD) individuals. Specifically, Cognitive Behavioral Analysis System of Psychotherapy (CBASP) has demonstrated effectiveness in treating chronic depression,6,7 but has not yet been studied in a large trial in persons with co-occurring alcohol dependence. Therefore, the purpose of this study is to discuss the therapeutic model of CBASP and the rationale for its proposed use in treating chronic depression and alcohol dependence concurrently. The paper begins with a description of the characteristics of persons who suffer from chronic depression and alcohol dependence and how these characteristics contribute to a challenging therapeutic scenario. Theories behind the comorbid development of the 2 disorders are then presented, followed by a brief review of the literature regarding treatment for co-occurring depression and substance use. The therapeutic model of CBASP and its adaptation for treating co-occurring disorders is then discussed. Finally, the paper concludes with the introduction of an ongoing research study using CBASP to treat chronic depression and alcohol dependence simultaneously.

CHARACTERISTICS OF CDAD INDIVIDUALS AND TREATMENT CHALLENGES

CDAD individuals possess unique characteristics, especially when compared with depressed-only individuals, which present unique challenges for the therapist and for therapy. CDAD patients are often younger at their first psychiatric hospitalization, have experienced a greater number of major depressive episodes and suicide attempts, and have poorer physical and psychiatric outcomes.8,9 Untreated alcoholism can exaggerate depressive states and enhance the chances of self-destructive behaviors, suicide attempts, and even suicide.10 Thus, there is a greater possibility of early death in CDAD individuals. Individuals who suffer from co-occurring alcohol dependence and major depression are also more likely to relapse and prematurely drop out of treatment.8 Individuals with CDAD typically report a high rate of adverse early home environments, a lifelong history of intrapersonal and interpersonal failure, and an earlier onset of disorders. They have higher rates of comorbidities, a more severe course of illness, and they demonstrate a predominant interpersonal style of avoidance and detachment.10,11,12 Early abuse or trauma history impairs development of adequate interpersonal coping skills, resulting in depression, social isolation, or withdrawal for many in this population.13 In addition, real-world and prolonged environmental stressors usually accompany CDAD individuals’ presenting complaints. They are often skeptical or ambivalent about change, and the processes of change are often slow, irregular, and inconsistent. In fact, a pattern of success followed by a setback is common and periodic plateaus in progress often occur.

Research suggests that poor treatment outcomes for CDAD individuals occur, in part, due to complex characteristics which these individuals possess that make their treatment more challenging.9,10,14,15 Chances of poor outcomes increase among individuals who (a) are diagnosed with both depression and alcohol dependence, compared with those diagnosed with a single disorder10,14; and (b) suffer from major depression during and/or after treatment of alcohol dependence. This second aspect is important because depressed mood has been found to be an important trigger for alcohol relapse.5,14 Importantly, there is some evidence16 that early intervention for alcohol dependence may improve not only problems with alcohol but also mood.

Challenges to treatment are numerous and the CBASP therapist must possess specific skills to be successful in administering therapy to this population. The CDAD patient may be ambivalent about changing either or both symptoms of alcoholism and/or depression and motivation for change is typically low for these patients, as is hope for the future. As stated, the processes of change are slow and irregular. The patient is typically interpersonally avoidant, and may lack effective interpersonal communication skills as well as
problem-solving and coping skills. They may use alcohol as a maladaptive coping strategy, placing themselves at risk for alcohol-related injuries and negative consequences.

Thus the therapist must possess skills to help clarify the patient’s ambivalence and increase motivation to change. These skills are similar to those a therapist may use in motivational enhancement therapies or motivational interviewing. In addition, the therapist must be patient and empathic, with an ability to be genuine and respond in a way that is judicious and self-disciplined. It is helpful if the therapist is aware of his or her own transference hypotheses and appreciative of his/her own interpersonal impact on others. Acquisition of such knowledge is formalized and is typically part of the required training for CBASP therapists. Such training and knowledge is conceptualized as crucial in helping CBASP therapists gain insight into their own interpersonal pulls and pitfalls that could inadvertently sabotage the therapeutic process and/or promote burnout in the therapist.

THEORETICAL EXPLANATIONS FOR COMORBID MAJOR DEPRESSION AND ALCOHOL DEPENDENCE

The comorbidity of chronic depression and alcohol dependence is prevalent and debilitating and warrants significant investigation regarding what predisposes the co-occurrence of these disorders. Research has found CDAD individuals to have several predisposing factors that increase the likelihood of experiencing comorbid major depression and alcohol dependence. Research on twin studies suggests a shared genetic risk factor for depression and alcoholism, and recent findings suggest an association between the CLOCK gene and the comorbid condition of alcohol misuse and depressive disorders. Data also supply evidence of overlapping neuroanatomic correlates for both disorders. For example, regions of the brain such as the ventromedial prefrontal cortex, which are important for homeostasis, emotional regulation, and decision making, show dysfunction in both depression and alcohol dependence. Other areas of the brain, such as the dorsolateral prefrontal cortex, the amygdala, and the insula have been reported to be important in both depression and alcohol dependence.

There are also psychological and behavioral correlates similar in both disorders. Brewer et al review the role of rumination and stress, which are both commonly seen in these 2 disorders. They conclude that depression and substance use disorders, including alcoholism, share several phenotypes such as stress vulnerability and rumination, which suggests possible mutual underlying neurobiological dysfunction. There is also evidence to support the claim that early childhood trauma plays an important role in comorbidity between the 2 disorders. Common scenarios reported by CDAD individuals include an early victimization or trauma (eg, death of a loved one, parental divorce or separation, physical or sexual abuse), which leads to major depression and subsequent alcohol abuse, or experiencing negative consequences from abusing alcohol that leads to major depression. Both scenarios are related to a third predisposing factor—that is, CDAD individuals have ineffective internal mechanisms to cope with negative psychological symptoms, such as depressive symptoms. As a result, CDAD individuals learn to use alcohol to alleviate depressive effect (eg, by modeling or operant conditioning), a theory known as self-medication. In effect, individuals who suffer from major depression are at an increased risk for alcohol dependence and relapse.

Finally, Merrill and Read have assessed multiple pathways leading to alcohol use. They found a difference between individuals who drink to cope and specific problem domains. In their study, alcohol use as a way to cope with negative effect was directly associated with academic/occupational difficulties, risky behaviors, and poor self-care. Nelson et al noticed that individuals who drink and display negative effect and depressive symptoms may be at additional risk for an increased severity of symptoms such as dependence.

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TREATMENT OF CO-OCCURRING DEPRESSION AND SUBSTANCE-RELATED PROBLEMS: A COMPARISON OF APPROACHES

Shared characteristics and etiological underpinnings of these 2 prevalent forms of psychopathology have resulted in an increased interest in their co-occurrence. Despite a recognized need for an integrated treatment approach for mood disorders and substance abuse—and chronic depression and alcohol dependence, specifically—empirical examination of such interventions is limited. Data from The National Survey on Drug Use and Health indicate that of adults experiencing co-occurring significant psychological distress and a substance use disorder, a majority did not receive treatment for either disorder.26 Only approximately 12% were treated for both disorders. This shortfall is likely the result of a lack of availability of empirically supported integrated treatments for comorbidities of this type.

As previously stated, there are several empirically supported behavioral treatments for depression and alcoholism as individual disorders, yet knowledge about effective integrated treatment options is far from complete. Carroll8 and others27,28 acknowledge that there have been few well-specified behavioral therapies with an integrated approach (vs. parallel) to treating symptoms of both disorders. Integrated treatment models are those in which treatment for both the mood disorder and the substance use disorder is delivered at the same time, in the same program, by the same staff. This is in contrast to sequential treatment, where the addiction is treated before the depression, or parallel treatment, in which patients are treated for mental illness in one system and for substance use disorders in another.29

Carroll8 reviewed the most common evaluated types of behavioral therapies for co-occurring disorders and included cognitive behavioral therapy (CBT), motivational interviewing (MI), and contingency management (CM). CBT and coping skills strategies have been shown to be effective across a wide range of substance use and psychiatric disorders, including alcohol dependence and depression,30–32 but controlled trials for co-occurring alcoholism and depression are limited, both in supply and design. In a qualitative review, Hides et al33 concluded that while CBT is more efficacious than no treatment control conditions, there is limited evidence to suggest that CBT is better suited for treating co-occurring depression and substance use compared with other psychotherapeutic interventions. In part, they cite poor heterogeneity between existing studies as a key reason why the evidence is inconclusive.

Conversely, a more recent quantitative review of the literature highlights the effectiveness of CBT to reduce depressive symptoms and alcohol use.34 In 1 study, a moderate effect on alcohol use and/or depressive symptoms with Cognitive Behavior Therapy-Depression (CBT-D) was demonstrated, but included only patients with elevated depression (Beck Depression Inventory ≥ 10), not diagnosed depressive disorders.14 Another study found that adding CBT-D for alcoholics with significant depressive symptoms was more effective on mood and alcohol use measures than standard treatment alone within an individual, but not a group treatment modality.35 However, it is possible that treatment effects were due to the added therapist contact in the individual condition.

More systematic investigations have also been conducted in recent years. One randomized clinical trial compared the effectiveness of computer-delivered versus therapist-delivered CBT with MI components.36 All patients had comorbid depression with substance misuse, most of which was alcohol misuse, and each received a single session of integrated CBT/MI before being randomized to a no treatment control condition, or 9 sessions of CBT/MI delivered by a psychotherapist or a computer. As hypothesized, treatment conditions were associated with significant reductions in alcohol use and symptoms of depression, with the long-term intervention having a greater impact. A similar RCT performed by Baker et al37 sought to determine the effectiveness of CBT/MI that is single-focused or integrated. Results found integrated treatment to be associated with greater improvements in alcohol use as
well as depressive symptoms when compared with single-focus interventions. Similar support has been found in adolescent samples, which highlight treatment gains even at 2 years posttreatment.38

Although there is a good empirical support for the effectiveness of MI in substance use disorders and related behavioral domains,39–41 well-controlled evaluations of MI as a stand-alone treatment or MI adapted for co-occurring disorders are rare, and demonstrate improvements in treatment engagement/retention, motivation, and satisfaction, but not improvements in mood or decreased substance use.42–44 In 1 small sample study (N = 5), MI was integrated with CBT for bipolar patients with comorbid substance use.45 Modest reductions in both mood symptoms and substance use were observed.

CM has demonstrated more robust findings when used with depressed cocaine-addicted populations.46,47 In a pilot study that used an integrated CM approach, opioid-dependent patients experienced decreases in depressive symptoms, but decreases in usage were not significant. However, it has not been implemented with CDAD individuals and CM is not always logistically or financially feasible.

In addition to those interventions highlighted by Carroll,8 mindfulness training and behavioral activation have seen more limited attention in the treatment of co-occurring disorders. Brewer et al21 reviewed the evidence for a shared mechanism in depression and substance abuse that might allow mindfulness training to reduce substance use and improve psychiatric symptoms. Another treatment study focused on inner-city substance users with mild to moderate depression and found that a modified version of behavioral activation was successful at reducing depressive symptoms in patients during residential substance abuse treatment.48 Interpersonal psychotherapy has also seen moderate support in the reduction of depressive symptoms, but less so for days abstinent from alcohol with the converse being the case for brief supportive therapy.49 Another study comparing integrated CBT with 12-step facilitation found both to be effective, with 12-step facilitation producing slightly better improvements in depression and abstinence.50 The aforementioned findings seem to support the hypothesis that an integrated therapy possessing components of motivational enhancement, cognitive and behavioral therapy, as well as management of reinforcements, would be most ideal when targeting co-occurring depression and alcoholism.

CBASP FOR CDAD INDIVIDUALS

Despite aforementioned similarities found among individuals dealing with chronic depression and alcohol dependence, investigation of more synthesized treatment approaches has occurred in a limited manner. “Third wave” CBTs represent 1 underexplored subset of treatment approaches. Specifically, CBASP51,52 has demonstrated effectiveness in treating chronic depression, demonstrating effects equal to antidepressant medications as well as enhancing the effects of pharmacotherapy.6,7 CBASP has yet to be studied in a large trial with persons with co-occurring alcohol dependence and chronic depression. However, in a case report from clinical practice, CBASP was effective in reducing symptoms of chronic depression and significantly reducing alcohol intake to healthy drinking levels in CDAD individuals.53 CBASP is especially proficient for use with the early-onset variety of unipolar mood disorders. Its etiological premise is that chronic depression arises as a result of a developmental history characterized by significant interpersonal trauma (eg, physical/sexual abuse) or low-grade but continuous stream of psychological insults (eg, punishment/rejection of some form); both lead to a preoperational form of thinking about one’s social world. This derailment is particularly characterized by a lack of causal awareness and egocentrism in the depressive patient. This often results in a presentation of poor functioning and/or low motivation for change.54

In addition, a lack of awareness for their interpersonal impact and poor interpersonal problem-solving skills is prevalent.51,52,54,55 CBASP takes a person-by-environment perspective in modifying depressive symptoms by raising
a patient’s awareness about their interpersonal impact on others.\textsuperscript{51,56,57} This is done by highlighting the interpersonal interaction as it occurs in the therapeutic setting. Recognizing one’s own stimulus value in the interpersonal context allows the chronic depressive to amend how he or she presents and copes with stressful interpersonal situations. CBASP holds that the interpersonal fear that drives avoidance, the central theme in many interpersonal failures, must be counterconditioned. This is done by aiding the patient in discriminating their experience with the therapist, from those experiences with harmful significant others, to create a sense of felt interpersonal safety that can then be generalized outside of the therapy setting.\textsuperscript{57}

Another major component of CBASP is situational analysis (SA). SA is an interpersonal problem-solving tool that is used in-session to help a patient actively reexperience an interpersonal encounter.\textsuperscript{51,56,57} The goal of SA is to elicit the original cognitions and emotions during the target situation. This involves having the client first isolate an event, describe it in exclusively behavioral terms, and identify the situational outcome. The goal of this exercise is to help the client identify alternative ways of behaving and thinking that would lead to more desirable consequences. New ways of behaving interpersonally are often met with obtaining desirable outcomes, reinforcing effective problem-solving skills, and allowing the patient to perceive his or her contingent relationship with the environment. Through these means the patient may acquire “perceived functionality”—that is, the patient’s ability to recognize and begin to change the interpersonal consequences of their behavior.

CBASP has demonstrated effectiveness in treating chronic depression, and is more effective than antidepressant monotherapy in individuals with early trauma or adversity.\textsuperscript{7,58-60} Moreover, both the therapeutic relationship and the ability of the patient to learn SA effectively have been shown to independently contribute to a reduction in depressive symptoms.\textsuperscript{61} In addition, there is some evidence to support the notion that CBASP may be efficacious for individuals who do not respond to a trial of antidepressant medications initially.\textsuperscript{62} CBASP has also been shown to outperform interpersonal psychotherapy in treating chronic depression,\textsuperscript{63} suggesting it may offer more when treating co-occurring chronic depression and alcoholism. Although 1 recent study\textsuperscript{64} found that neither CBASP nor supportive psychotherapy was more effective than medication alone for chronically depressed treatment-resistant patients, the lack of positive findings in that study may be related to the small number of CBASP sessions (mean = 12.5 sessions) and an aspect of the study design that focused on pharmacological switching and augmentation, which may have had a negative impact on patients’ interests in and expectations of psychotherapy.\textsuperscript{65} In other research, CBASP has been used to treat chronically depressed pregnant smokers, and was found to be more effective than standard treatment at increasing abstinence and decreasing depressive symptoms at 6 months posttreatment.\textsuperscript{56} CBASP has also proven useful in a small sample study demonstrating that increases in positive effect and a decrease in depressive symptoms are associated with a greater likelihood of prolonged abstinence from cigarette smoking.\textsuperscript{66}

**RATIONALE FOR AND ADAPTATIONS OF CBASP FOR CDAD INDIVIDUALS**

Those entering substance abuse treatment programs with co-occurring disorders report using multiple drugs, having more recent admissions to psychiatric and medical facilities, and experiencing more severe medical, social, and family problems compared with those diagnosed solely with a substance use disorder.\textsuperscript{23} These characteristics suggest the need for specialized treatment addressing depression and alcoholism simultaneously. Substance Abuse and Mental Health Services Administration in the United States\textsuperscript{26} has come to similar conclusions in their recommendations for Center for Substance Abuse Treatment improvement protocols with co-occurring disorders, suggesting individualized, integrated
dual primary diagnosis-specific treatment interventions matched to diagnoses, phase of recovery, stage of change, and severity. Interestingly, no studies have evaluated the use of a behavioral treatment approach that can address these specific mood and addiction symptoms that characterize the CDAD individual.

CBASP is a behavioral treatment that addresses the unique characteristics of chronically depressed individuals, most of which are highly relevant for alcohol-dependent individuals as well. CBASP is designed for persons who may (a) be less functional and less motivated to change; (b) have traumatic or impoverished developmental or reinforcement histories; and (c) lack awareness of their interpersonal impact or have poor interpersonal problem-solving skills. Thus, CBASP seems to be a plausible behavioral approach for use in CDAD individuals who may report traumatic developmental histories, manifest impoverished interpersonal relations, interactions and coping skills, and demonstrate additional chronic underfunctioning. Because of its structured but individualized and collaborative design, emphasis on teaching-effective coping strategies, and use of motivational, cognitive, behavioral, and interpersonal techniques, CBASP is uniquely suited for use in treating alcoholism in the context of chronic depression.7,67

The major goals of CBASP are: (a) to enable patients to feel increased emotional safety, thus allowing them to more fully approach and engage in treatment and reduce avoidance behavior, including drinking; and (b) to allow patients to recognize how they contribute to their own interpersonal pathology (perceived functionality) and begin to learn how to negotiate interpersonal situations successfully and without the use of alcohol. Importantly, CBASP provides an empirical method to facilitate and measure exactly what and how much is being learned during the course of therapy. Felt emotional safety in the therapeutic dyad and learned acquisition of perceived functionality are both hypothesized to be related to the outcome of treatment and, over time, to the maintenance of the therapeutic gains. These skills can be measured in multiple correlated ways, including evaluation of learning in session through the achievement of therapeutic interpersonal tasks, performance on psychological tests of prediction of interpersonal response, and fMRI assessment of the neurobiological correlates of perceived functionality that have been identified in chronic depressives.68

In sum, treatment for CDAD individuals must target the underlying interpersonal issues and skill deficits of the individual in order to be most effective. CBASP is a behavioral treatment that can be adapted to comprehensively address these issues to successfully treat both alcohol dependence and chronic depression simultaneously.

MATERIALS AND METHODS

This study was approved by the Institutional Review Board of the University of Virginia. Participants were recruited by flyers posted in the community. A 20-session pilot study examining the use of our augmented CBASP for persons with co-occurring chronic depression and alcohol dependence was used to demonstrate if CBASP is effective in reducing depressive symptoms and alcohol consumption in these CDAD participants when posttreatment ratings are compared with pretreatment levels.

Sessions were individually administered weekly for 1 hour by 2 trained PhD level clinical psychologists with extensive experience in addictions treatment and depression. These therapists completed a week-long training course with the developer of CBASP, Dr James McCullough, Jr, and also completed 2 months of weekly hour-long trainings with Dr K.J.P., who is a certified trainer of CBASP with the CBASP National Training Institute. A revised CBASP for Co-Occurring Chronic Depression and Alcohol Dependence was created and used for the therapy study. The therapists also recorded their sessions and received weekly supervision to ensure adherence to the treatment protocol. Sessions were audiotaped to be rated for adherence, and follow-up data regarding alcohol intake and
depressive symptoms collected at 1-, 2-, and 3-months postintervention. Preliminary results from this small study indicate that this patient population is willing to seek and participate in such extensive and intensive treatment. The results section describes the course of treatment for 2 participants.

Participants
Participants were enrolled if they met the following inclusion criteria: current DSM-IV diagnosis of alcohol dependence and a chronic depressive disorder; literate in English and able to read, understand, and complete the rating scales and questionnaires accurately, follow instructions, and make use of the behavioral treatments; express a wish to stop drinking and receive treatment for depressive symptoms; and willingness to participate in behavioral treatments for alcoholism and depression. Participants were excluded from the study if: they had a current Axis I DSM-IV psychiatric disorder other than alcohol or nicotine dependence or a chronic depressive disorder that, in the clinician’s opinion, warrants treatment or would preclude safe participation in the protocol; had a serious medical comorbidity requiring medical intervention or close supervision, including a history of dangerous symptoms of withdrawal from alcohol such as seizure; had gross neurological disease; mental retardation; or were actively participating in other individual psychotherapy.

Measures
Drinking
The drinking parameters used in the study were drinks per drinking day (DDD) and percent days abstinent (PDA), assessed using the timeline follow-back technique. DDD was assessed over the past 90 days at screening, and both DDD and PDA were assessed over the previous week at subsequent visits.

Depression
Ratings of depressive symptom severity were collected through the Hamilton Rating Scale for Depression-24. This was collected weekly by a trained research associate.

Procedure
We developed an enhanced integrative 20-session CBASP for use in reducing both depressive symptoms and alcohol intake in CDAD patients. The augmented CBASP includes all the aspects of traditional CBASP and adds coping skills training for reducing alcohol intake. Sessions were individually administered weekly for 1 hour by 2 trained PhD level clinical psychologists, and audiotaped to be rated for adherence. Follow-up data were collected at 1-, 2-, and 3-months postintervention. There was no comparison control group, instead participants’ progress during and after treatment was evaluated compared with their pretreatment measures of depression and alcohol consumption. One of the most important components of successfully conducting CBASP with this population is helping the patient discover the causal connections between their mood symptoms and drinking behavior and ultimately change the functional linkages between their depression and drinking. The drinking behavior is conceptualized as a maladaptive coping strategy that is often an outcome of interpersonal situations for this patient population. Drinking behavior is also conceived of as avoidance behavior, which interferes with learning and practicing effective interpersonal problem solving and coping. Further augmentations include additional assessment and monitoring of stage of change and motivation levels for both depressive symptoms and alcohol use. During the middle phase of treatment and in session after the Coping Survey Questionnaire (SA) has been remediated, alcohol reduction coping skills are identified and taught in the same manner that traditional CBT is conducted. Significant adaptations for use with this population involve setting and assessing alcohol consumption goals in addition to depressive symptoms and quality of life/level of functioning goals for treatment. A harm reduction approach, similar to that utilized in CBT for alcohol dependence, is used to address alcohol consumption. Thus, patients do not need to be abstinent when...
in treatment and do not necessarily have to set abstinence as their goal, although it is preferred. The overall approach to symptom change is compatible with the CBASP essence of treatment, which allows the patient to establish how the therapy session will proceed and enables the patient to do the work of change.

RESULTS

Participant 01

Participant 01, “Denise” is a 54-year-old, white female who is divorced and lives alone. She works full-time as a nurse. At intake, she was diagnosed with dysthymia (early onset), major depressive disorder (recurrent, in partial remission), and alcohol dependence. Denise noted that interpersonal stress at work and with family members was a primary trigger for her depression. She recognized that she drank to avoid her negative emotions and interpersonal problems. At intake, stage of change data indicated that Denise had already begun to reduce her alcohol intake and that she was ready to reduce her symptoms of depression. She reported that she had been on vacation for 3 weeks before intake and that her symptoms of depression and alcohol use had reduced as a result. Her stated goals for treatment were to learn how to manage her mood so that she no longer used alcohol to cope with depression, and to drink at a reduced level because she enjoys the taste of alcohol. As shown in Figure 1, at session 1, she was drinking 28 drinks per week and her score on the Hamilton Depression Rating Scale was 14. By session 10, Denise began effectively using SA to solve interpersonal problems. As can be seen in Figure 1, she continued to practice SA using the Coping Survey Questionnaire on a weekly basis. By session 16, she reported that she no longer needed to drink to manage her mood. She noted, “for the first time in my life, I am finally taking control of situations and facing my demons.” Much of her ability to take control of situations in her life involved learning through SA to set boundaries with others. Setting boundaries with others was difficult for her due to fear of interpersonal rejection. Her difficulty setting boundaries often caused her to feel taken advantage of by others, which led to depression and subsequent drinking behavior. Her fear of interpersonal rejection was also related to her use of alcohol to cope with these feelings. As shown in Figure 1, she continued to practice SA using the Coping Survey Questionnaire on a weekly basis. By session 16, she reported that she no longer needed to drink to manage her mood. She noted, “for the first time in my life, I am finally taking control of situations and facing my demons.” Much of her ability to take control of situations in her life involved learning through SA to set boundaries with others. Setting boundaries with others was difficult for her due to fear of interpersonal rejection. Her difficulty setting boundaries often caused her to feel taken advantage of by others, which led to depression and subsequent drinking behavior. Her fear of interpersonal rejection was also related to her use of alcohol to cope with these feelings.
to fear of making mistakes. Denise’s transference hypothesis was “if I make a mistake with my therapist, I will disappoint her and she will think I am not good enough.” This fear of interpersonal rejection was addressed in treatment using the Interpersonal Discrimination Exercise, and by session 7 Denise was able to discriminate between the feedback from the therapist and feedback from significant others when she made a mistake. As such, she

FIGURE 2. Number of Coping Survey Questionnaires completed, Hamilton Rating Scale for Depression scores, and drinks per week by session for participant 02. Session 0 refers to the participant’s scores at baseline.

FIGURE 3. Differences between 90 days pretreatment (black) and last 90 days in treatment (white) on 4 drinking variables for the study participants.
reported an increased sense of safety and she demonstrated an increased ability to assert herself with the therapist. Across the final weeks of treatment, Denise’s learning generalized and she was regularly setting appropriate boundaries with significant others in her life. By her final session, she was down to 17 drinks per week and her score on the Hamilton Depression Rating Scale was 3. At termination, Denise stated that she no longer felt fear or guilt about expressing her limits to others and setting boundaries.

Participant 02

Participant 02, “Paul” is a 45-year-old, white male who is divorced and lives alone. He works part-time as a food vendor and also receives monthly social security disability benefits. At intake, he was diagnosed with major depressive disorder (recurrent) and alcohol dependence. Paul reported an extensive drug and alcohol use history, further noting how his substance use helped him to avoid negative emotions and interpersonal problems. At intake, stage of change data indicated that he was planning to reduce both his alcohol intake and symptoms of depression. His stated goals for treatment were to learn how to better manage his mood so that he no longer used alcohol to cope with depression (he reported no drug use for the past 5 years), and to drink at a reduced level because he enjoys drinking alcohol. As shown in Figure 1, at session 1, he was drinking 48 drinks per week and his score on the Hamilton Depression Rating Scale was 16. As can be seen in Figure 1, he continued to practice SA using the Coping Survey Questionnaire on a weekly basis and began to gain an understanding of the importance of communicating with others to achieve socially desirable outcomes. This was especially true with regard to expressing negative effect to others. Paul’s transference hypothesis was “if I express negative effect, emotions, or feelings to my therapist, then he will be angry or upset with me, and reject me.” This fear of interpersonal rejection was addressed in treatment using the Interpersonal Discrimination Exercise. Despite the participant’s difficulty discriminating between feedback from the therapist and feedback from significant others when he expressed negative effect, he reported an increased sense of self-confidence to assert himself with the therapist and others. In addition, Paul stated that although he was more concerned with others’ reactions to his assertiveness in the past, across the final weeks of treatment, he was more concerned with obtaining socially desirable outcomes than with what others’ reactions were to him. In his final session, Paul was drinking 15 drinks per week and his score on the Hamilton Depression Rating Scale was 3.

DISCUSSION

CBASP can be successfully augmented and implemented within a patient population in much need of effective treatment options. Although neither patient set abstinence as their drinking goal, instead opting to cut back or reduce their alcohol intake to a less risky level, they made progress on these goals and remained engaged in treatment. Both patients reduced their depressive symptoms dramatically over the course of 20 weeks. More importantly, both patients were able to gain insight into the negative impact of their transference hypotheses and avoidance behaviors upon their mood and drinking behavior, and begin to implement causal thinking to approach and solve interpersonal problems. Indeed, preliminary investigations of this pilot study data suggest that treatment is most effective when tailored to the underlying interpersonal issues and skill deficits of the patient as presented in the Transference Hypothesis.

Preliminary results from the research examining CBASP for CDAD outpatients in individual therapy are presented in Figures 1–3, but obviously should be interpreted with caution due to the very small sample size (N = 2). However, the results are promising, as both participants showed reductions in their drinking measured through the Timeline Follow-back Calendar and depressive symptoms measured through the Hamilton Rating Scale for Depression, as the number of
completed Coping Survey Questionnaires increased. Additional completed study participants are necessary to confirm these preliminary findings. In addition, future exploration of the impact of specific learning acquisition of coping skills and not just exposure to the number of learning opportunities should be evaluated over time to explore the impact of acquired knowledge on outcomes.

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