RISK FACTORS FOR DEPRESSION?

The Abuse of Alcohol & Other Substances

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I. Major Depressive Dis (MDD) & Sub Use Dis (SUD): The Prevalence & Clinical Synergies!

- Lifetime prevalence of MDD is associated with increased prevalence of an SUD in the general population (OR=2.4-5.2)
- Current prevalence of SUD in MDD is 8.5-21.4% in the general population
- Patients seeking substance use treatment have an increased lifetime prevalence of MDD:
  - Alcohol: 12-67%
  - Cocaine: 31-52%
  - Opioid: 44-54%
  - Nicotine: up to 60%

Davis LL et al. Compr Psychiatry 2005
Torrens M et al. Drug & Alcohol Depend 2005

Sequenced Trt Alternatives for Depression (STAR*D) (N=1484) – Davis LL '05

- 28 % Patients with SUD co-morbidity more likely to be:
  - Men
  - Divorced or never married
  - Younger age of onset of depression
  - Higher rate of previous suicide attempts
  - SUD did not alter depressive symptoms except for greater hypersomnia, anxiety & suicidal ideation
- Patients with co-morbidity have greater functional impairment

Canadian Community Health Survey (2002) N=36984 – Patten, Currie, Wang, Beck, Maxwell & el-Guebaly (2005)

- 12 m MDD among Alc/Drug Use Dis = Gen Pop x 2-4
- Risk of suicide thoughts = Gen Pop x 4 (SUD); x 12 (MDD)
- Mental health trt utilization = Gen Pop x 3 (SUD); x14 (MDD)
- Disability & Impaired Function: Association with Mood & Anxiety Dis > SUD but compounded by comorbidity

II. ETIOLOGY OF COMORBIDITY: The chicken & egg…or other!

A. Depression initiates alcohol dependence "self medication" – research ?
   - Earlier onset & symptoms persistence after withdrawal

B. Alcohol Dependence initiates depression
   - Alcohol, a depressant spec with chronic use
   - In 70% of men, alcoholism precedes depression & the reverse for females
   - Longer duration of alcohol abuse ⇒ more depression

C. Both Conditions share a common factor
   - Common gene ?? but common stressful events, particularly PTSD: close association in veterans & civilians (HPA axis, noradrenergic?)
   - Other Axis I, II, or III (fibromyalgia, chr pain) comorbidities

D. "Dry drunk" or delayed depression while abstinent
   - "Not working the program" versus an "opportunity for growth"
   - Socioeconomic stressors ⇒ hopelessness ⇒ support
   - Association with Axis II disorder ⇒ extended trt

III. Depression & SUD's Concurrent Management: Benefits & Challenges

PREVENTION - "Moderate drinking": 12 drinks/wk for males, 9 drinks/wk for females.
How many if depressed? with medication?
- Reason for drinking? Resulting effect? 5+ drinks threshold?

BIOLOGICAL INTERVENTIONS

Detoxification first!
- Monitor evolution for at least 1-2 wks to screen out substance effect
- Depression may precede use or persist during abstinence

Concurrent SUD is NOT a barrier to depression treatment!

Early Intervention: if marked vegetative (sleep, appetite) symptoms
psychotic features
suicidality
family or personal (earlier onset) history

Depression & SUD's Concurrent Management (b)

Pharmacology alone: a modest benefit!
- Nunes & Levin '04 meta-analysis RCT's (8 alcohol, 6 other drugs):
  - 5 tricyclics, 7 SSRI's, 2 other class; concurrent therapy required
- Choice? - tailor target symptoms: sleep, anxiety, physical co; lethargy
  - side effects & compliance, i.e., depressed libido, weight gain
  - history, i.e., person or family with similar medication
  - drug-drug interaction
  - treat depressive symptoms to full remission
- Adherence? Patient - concern about mood alteration & addiction
  - "The AA Member: Medication & Other Drugs", 1984
  - a healthy desire to be involved; no magic bullet

  Clinician - fear of toxic interaction
  - "wait & see"? Medication may reduce relapse risk

B. PSYCHOLOGICAL

- **Motivational Enhancement Treatment (MET), i.e., FRAMES**
  Feedback Responsibility Advice Menu Empathy Self-efficacy
- **Psychoeducation: - Support & instillation of hope**
  - Link sleep disturbance, low mood, amotivation to substance use
- **Cognitive Behavioral Therapy, i.e., adapted to concurrent management**
  - **Relapse Prevention, i.e., Craving Triggers: Thoughts/Feelings; Behaviors; Consequences**
  - **Behavior: "control/abstinence" before cognition "if only I knew why"**
  - **Avoidance goal: decrease for depression, increase for SUD**
- **Mindfulness: the above plus Emotional Regulation**
- **Abstinence & commitment to Mutual Help & 12-Steps**

C. RECOVERY FROM DYSTHYMIC DIS & ADDICTIONS:

"CHRONIC, PRIMARY & PROGRESSIVE"

How to contain a disease & optimize personal & family health?
An alternative to serial episodes of acute care

FLEXIBLE BUILDING BLOCKS! concept: addiction ⇒ mental health
- **Individual's Stage of Change**
- **Goal: harm reduction⇒ abstinence**
- **"Recovery capital" i.e., resources personal & community ⇒ many pathways**
- **Treatment & support services: match with different individuals or same individual at different stages**
- **Role for Family & Mutual Help**

RECOVERY JOURNEY "SELDOM LINEAR"
- **Engagement & stabilization: diagnosis, denial, cravings, …**
- **Early: triggers, negative affects, cognitive distortions, …**
- **Middle: relation problems, relapse issues, spirituality**
- **Late: review above, lifestyle balance, unresolved personality & other issues**

POLICY IMPLICATIONS

- **Recognition of prevalence & clinical SYNERGIES between Depression & SUD's:**
  - **Current/planned strategies to address the overlap between these PH issues**
  - **2020 Burden of Disease (DALY): in developed regions Males Alc> Depression**
  - **Role of the MH Commission with SUD/Addiction to be further defined**
  - **Bridging the separate care systems & cultures as valued partners**
- **Research into Depression & SUD's Concurrent Management:**
  - **Parameters of "moderate drinking" with comorbidity**
  - **Clinical trials addressing comorbidity, no longer an exclusion criterion**
  - **The next frontier with "real people"**
- **Implications for some of "Recovery"- as a life long journey: lifestyle & social support, health care, family & mutual help**