A Framework for Relating Alcoholism and Depression

David A. Sedlacek, PhD, and Sheldon I. Miller, MD
Cleveland, Ohio

A diagnosis of primary, as opposed to secondary, depression in alcoholics is not easy to make and not always a helpful clinical guide when it is made. A useful framework for understanding alcoholism and depression clinically is to distinguish between alcoholics who are actively drinking, newly sober, or in recovery. Medication for depression should never be given to an actively drinking alcoholic. Newly sober alcoholics and those in various stages of recovery are expected to be depressed. Medication is generally not needed to deal with depression due either to withdrawal or to life problems associated with recovery from alcoholism. The use of antidepressant medication may be appropriate only when depression continues after all other avenues of therapy have been exhausted.

A review of the literature discussing the relationship between alcoholism and depression shows that the current state of knowledge in this area leaves much to be desired. Several reports assume that the psychological state of newly detoxified alcoholics is representative of that of alcoholics in general.[1-3] Other studies are weak in the area of diagnostic methods.[4] Although several authors seem to have an adequate understanding of the phenomenon of alcoholism, in general there is a failure to differentiate the relationship between alcoholism and depression in alcoholics who are drinking, in withdrawal, in treatment, and in recovery. Although a complete discussion of alcoholism and depression is beyond the scope of this paper, an attempt will be made to develop a framework that can be used to sort out current knowledge and structure future research on alcoholism and depression.

From the Department of Psychiatry, School of Medicine, Case Western Reserve University, Cleveland, Ohio. Requests for reprints should be addressed to Dr. David A. Sedlacek, Project Cork, School of Medicine, 2119 Abington Road, Cleveland, OH 44106.

Primary vs Secondary Depression in Alcoholics

Primary depressive individuals are generally described[5-7] as those who first developed depression and only later became alcoholic. Several studies point out that women comprise the majority of this type of depressive alcoholic. Secondary depressive alcoholics are those who were first alcoholics and only later in life developed depression in the context of their alcoholism. Although there has been no definitive study documenting the relative proportions of primary and secondary psychiatric conditions related to alcoholism, the Cadoret and Winokur study yielded the following results[5]: Of 259 alcoholics, 173 (67 percent) were primary alcoholics, 31 (12 percent) were primary depressives, and 55 (21 percent) had other primary diagnoses. Of the primary alcoholics, 71 (41 percent) also had secondary depression diagnosed. Of the primary depressives, 26 (84 percent) were women. A total of 102 (39 percent) of the 259 alcoholics were diagnosed as having either primary or secondary depression. Nearly 50 percent of the

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women and 32 percent of the men studied were depressed. Depression was by far the single most frequent psychiatric symptom diagnosed in this group of alcoholic patients.

Even when the primary diagnosis has been successfully established, the appropriate course of treatment may not be clear cut. Logically, one might attempt to treat the primary syndrome first. Woodruff et al, however, observe that even though depression may have occurred prior to the onset of alcoholism and contributed to the development of alcoholism in some patients, depression at this point in the patient's life may no longer be the principal problem. In their words, "alcoholism finally becomes autonomous."[6] Therefore, vigorous treatment of the primary condition of depression may not produce satisfactory results. A better course might be to treat first the principal problem, that is, that problem which is having the most serious impact on the patient's life at this point in time.

Diagnostic Methods

Other studies report a wide variation in the estimates of prevalence of depression in alcoholics. The estimates range from 3 percent primary affective disorders among alcoholic men[8] to 98 percent depression among patients requesting treatment at a halfway house.[4] A part of this discrepancy is a definitional problem. If one speaks only of primary affective disorder among men, for example, the 3 percent estimate made by Winokur et al[8] corresponds well with the data in the Cadoret and Winokur study (5 of 259 for 2 percent).[5] Caution must be exercised that comparable populations be used when citing and interpreting statistics.

Another source of variation is the type of instrumentation used. Frequently used measures of depression include the Zung Self-Rating Depression Scale, the Beck Depression Inventory, the Hamilton Depression Rating Scale, the depression scale of the Minnesota Multiphagic Personality Inventory, clinical observation, and self-report.[4] Several of these scales measure different aspects of depression. For example, the Zung scale gives greater weight to physiological symptoms, whereas the Beck Depression Inventory is a more sensitive indicator of the degree of cognitive awareness of subjective feelings of depression.[4] The use of the Zung scale during the withdrawal period, therefore, might predictively yield higher scores than the Beck inventory during this period. Butterworth administered the Zung scale to a group of patients in withdrawal and found that 75 percent were clinically depressed.[9] Blum and Levine administered the same instrument to patients who had been sober an average of 3.79 months and reported that "the alcoholics in the present sample actually reported such low levels of depression that the group mean was well below those levels Zung (1965) and Beck (1967) consider even mildly depressed."[10] From these studies it can be concluded that in designing or interpreting research relating alcoholism and depression, several factors must be considered: the definition of depression used (eg, primary vs secondary depression), the construct which the instrument used is designed to measure (eg, physiological symptoms vs cognitive awareness), and perhaps most importantly, the point in treatment at which the test is administered (eg, during withdrawal vs after a period of sobriety).

Management

Zetzel stressed the importance of understanding the nature of a patient's depressive feelings and how he deals with them rather than looking only at the presence or absence of depression.[11] "Just as healthy psychological development requires the ability to tolerate and use anxiety," she wrote, "so an ability to accept and tolerate depression is a vital part of normal, healthy development." If the above premise is accepted, individual or group psychotherapy would be the treatment of choice in the majority of cases. In addition to this philosophical rationale, there are metabolic, pharmacologic, and other systemic reasons that a conservative approach to the use of medication in the treatment of depressed alcoholics is warranted. A clear understanding of the dynamics of alcoholism supports this contention.

Pretreatment

There are a number of reasons that a conservative approach to the use of medication for depression is especially important for actively drinking alcoholics. First, it is especially difficult to make a diagnosis of depression during a period of active drinking. Pharmacologically alcohol is a depressant. In nonalcoholics the sedative effect of alcohol is directly proportional to the amount of the drug consumed. In alcoholics, sedation may not

occur gradually, but becomes evident only when the tolerance level of that individual has been reached. These tolerance levels are generally very high until the chronic stage of alcoholism has been reached, when there is a sharp decrease in the alcoholic's ability to tolerate alcohol. After a period of heavy drinking, the alcoholic will often feel the need to stop for a while, usually because of physical or financial reasons.

It is during these hiatus periods that an alcoholic will most likely seek the services of a physician. Poor nutrition, the effects of withdrawal, and the realization of the personal and familial damage of the current drinking episode will combine to present a picture of clinical depression. The individual may be physically lethargic, unable to sleep, nervous, guilt ridden, and remorseful. If unaware of the patient's alcoholism, a physician might diagnose severe depression and elect to prescribe antidepressant medication.

This course of treatment presents a dual danger to the patient. First, because of their tendency to abuse chemicals, alcoholics are susceptible to developing a dependence on a second drug, the one prescribed by the physician. There are well-documented cases of dual addiction developing in response to the inappropriate medication of practicing alcoholics. The second very real danger is overdose. It is unrealistic to assume that without treatment an alcoholic will either stay sober or use medication as prescribed. The exact potentiating effect of an alcohol-depressant drug combination is difficult to predict, but the combination can certainly result in severe adverse physical consequences, even death. At the very least the intended therapeutic effect of the depressant drug will be nullified by alcohol.

Several studies have also established a link between alcoholism, depression, and suicide. Mayfield and Montgomery describe a suicide attempt based on alcohol induced depression which occurred after two or more weeks of excessive drinking.[12] This depressive type of suicide attempt is accompanied by increased depression in mood, psychomotor retardation, and social withdrawal and is often lethal. Some alcoholics without the clinical signs of depression also attempt suicide, and Beck et al show that a common element in suicide attempts among alcoholics is the feeling of hopelessness or the inability to see realistic alternatives to their present situation.[13]

Given the above description, it would be necessary for a physician first to be able to diagnose alcoholism in order to determine whether the depressive systems observed result from primary depression or are related to a recent drinking episode. After having diagnosed alcoholism, the physician should attempt to motivate the patient to accept alcoholism treatment or refer the patient to someone who specializes in alcoholism treatment. The essential message to impart to the patient is that there is a way out of the present situation, and that the way out is through treatment of the alcoholism first.

During Treatment

Acute Withdrawal

During the first several days after cessation of drinking, the alcoholic will experience mild to severe withdrawal symptoms. The physical withdrawal syndrome has been well described. There is also, however, a psychological component to acute withdrawal which is clearly depressive in nature. In addition to the depressed feelings that accompany poor physical well-being, the alcoholic often experiences mood alterations directly related to the metabolic readjustment the body must make in response to the removal of alcohol. As the alcoholic's cognitive functioning begins to return to normal, he may begin experiencing reactive depression due to familial, employment, or other social problems. The realization of the loss of the ability to drink also contributes to the depressive state often observed in early withdrawal.

Again, treatment of depression related to acute withdrawal should take the form of helping to put the patient in touch with the immediate reasons for the depressed feelings. Kielholz states that "it is therefore only possible to make a diagnosis of depression after the detoxification is complete and the 'withdrawal depression' has been resolved."[14] The use of medication to control withdrawal depression is usually contraindicated, since the depression usually clears as the withdrawal subsides.[15]

Postacute Withdrawal Syndrome

Several authors, including Gorski[16] and Kielholz,[14] have described a postacute withdrawal syndrome which lasts up to 18 months in many alcoholics. There are many phenomena that can carry over from the acute withdrawal syndrome,

including insomnia, anxiety, memory deficits, inability to concentrate, weariness, oversensitivity, impotency, and tremor. In addition, the stress of reestablishing oneself in one's family, job, and community can be quite stressful and result in depression if success is not achieved early on. Unfortunately, many alcoholics are not counseled that these symptoms and the accompanying depression are normal for this stage in the recovery process and are not helped to see these symptoms in perspective. Too often the result is relapse. A physician should not be immediately alarmed at the continuation of depressive symptoms during this period in treatment and should encourage the patient to explore these phenomena with a knowledgeable counselor. Because of the patient's propensity toward addiction and toward finding "quick and easy" solutions to problems, antidepressive medication should be prescribed conservatively, if at all.

It is during the postacute withdrawal stage that a diagnosis of primary depression may be considered. Curlee describes patients with fundamental depression resulting from "oral deprivation and oral rage associated with the infantile personality."[17] Other alcoholics show a depressive-masochistic personality in which patients cannot accept their own strengths and achievements and tend to spoil their success by drinking. If it is determined that after a period of sobriety depression continues to be the principal problem, and if it is of a primary, not a reactive, nature and strong attempts at psychotherapy have not proven fruitful, the use of an antidepressant psychotropic agent should be considered. The choice of antidepressant is vital. As Kielholz notes, "different antidepressants influence the individual symptoms of a depressive syndrome to different degrees."[14]

Posttreatment Phase

It must be noted that the recovery from alcoholism is often a long-term effort, even if sobriety is maintained. In addition to the initial readjustments to the family, job, and community, the recovering alcoholic must struggle with issues of personal identity and the meaning of his or her existence. It is often several years before some degree of tranquility is reached, even in the most highly motivated individual. It is to be expected that periodic depression will surface during the normal course of the recovery process.

Summary

The intent of this paper is to provide a framework for understanding the relationship between alcoholism and depression. Most studies reviewed on this topic failed to set their research findings and observations in a contextual framework with an adequate understanding of the dynamics of alcoholism and its treatment. The prominent presence of depression is apparent throughout the life of the active and recovering alcoholic. It is hoped that through appropriate research leading to more effective treatment, the relationship of depression to alcoholism will be more clearly defined, and the recovery from alcoholism will be more easily managed for those alcoholics experiencing depression.

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