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Depressive symptoms as a predictor of alcohol relapse after residential treatment programs for alcohol use disorder

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Abstract

Alcohol use disorder (AUD) and depressive disorders often co-occur. Findings on the effects of major depressive disorder (MDD) or depressive symptoms on posttreatment alcohol relapse are controversial. The study's aim is to examine the association of MDD and depressive symptoms with treatment outcomes after residential AUD programs. In a naturalistic-prospective, multisite study with 12 residential AUD treatment programs in the German-speaking part of Switzerland, 64 patients with AUD with MDD, 283 patients with AUD with clinically significant depressive symptoms at admission, and 81 patients with AUD with such problems at discharge were compared with patients with AUD only on alcohol use, depressive symptoms, and treatment service utilization. MDD was provisionally identified at admission and definitively defined at discharge. Whereas patients with MDD did not differ from patients with AUD only at 1-year follow-up, patients with AUD with clinically significant depressive symptoms had significantly shorter time-to-first-drink and a lower abstinence rate. These patients also had elevated AUD indices and treatment service utilization for psychiatric disorders. Our results suggest that clinically significant depressive symptoms are a substantial risk factor for relapse so that it may be important to treat them during and after residential AUD treatment programs. © 2011 Elsevier Inc. All rights reserved.

Keywords: Depression; Alcohol relapse; Residential treatment programs; Predictor; Naturalistic multisite study

1. Introduction

Alcohol use disorder (AUD) and major depressive disorder (MDD) often co-occur (Curran, Booth, Kirchner, & Deneke, 2007; Curran, Flynn, Kirchner, & Booth, 2000; Greenfield et al., 1998). Curran et al. (2007) reported that 40.3% of patients who met *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (*DSM-IV*) criteria for lifetime MDD also met criteria for alcohol abuse or dependence. In various studies, up to 70% of patients who attended treatment for substance use disorder (SUD) also had comorbid depression. Conversely, 8.5% to 21.4% of patients with MDD had a current SUD, and 27% to 40% had a lifetime comorbid SUD (Davis et al., 2005). Nearly one quarter of men (24.3%) and half of women (48.5%) with a lifetime AUD report depressive symptoms anytime in their life (Curran et al., 2000).

Depression among people with AUD is associated with poorer treatment outcome such as a return to drinking, relapse, and various problems in psychosocial functioning and places people at great risk of chronic impairment (Brown et al., 1998; Davis et al., 2005; Thase, Salloum, & Cornelius, 2001). However, equivocal results can be found on the relation between MDD and time-to-first-drink and relapse. A current MDD among adolescents (Cornelius et al., 2004), at time of admission to treatment (Greenfield et al., 1998) and after treatment ends (Curran et al., 2000), was associated with earlier relapse to alcohol use. Conversely, a current MDD diagnosis was not significantly related to alcohol relapse in two similar studies (Brown et al., 1998; Sellman & Joyce, 1996). Nevertheless, adult studies have shown that depressive symptoms were higher pre- and posttreatment for patients with MDD than for those with AUD only (Brown

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et al., 1998). Lucht, Jahn, Barnow, and Freyberger (2002) also found that MDD at admission was not an indicator for relapse; however, a significant decrease of depression severity was associated with longer abstinence duration.

Other studies did not focus on MDD among patients with AUD but on depressive symptoms that can be a substantial risk factor of relapse after AUD treatment (Curran et al., 2000). More severe symptoms at admission were related to worse alcohol use outcomes such as alcohol craving, treatment attrition, and relapse to former drinking patterns (Brown et al., 1998; Curran et al., 2000). Although Lucht et al. (2002) found that elevated scores on scales of depressive symptoms at discharge were not related to a higher risk of relapse, Curran et al. (2007) reported that depressive patients with AUD were 4.1 to 6.9 times more likely to relapse with alcohol at various follow-up periods than nondepressed patients with AUD (Curran et al.). Overall, the association of new and persistent depressive symptoms was quite similar across follow-up periods (Curran et al., 2000). However, there are two studies that did not find any relation between depressive symptoms and time-to-first-drink or relapse (Greenfield et al., 1998; Lucht et al., 2002).

This study aims to examine the difference of clinical MDD diagnosis and clinically significant depressive symptoms on AUD outcomes after residential AUD treatment programs. Patients with clinically significant depressive symptoms and AUD will be assigned to three groups according to their MDD diagnosis or according to their clinically significant depressive symptoms at admission to and at discharge from, respectively, a residential AUD treatment program. These three groups will be compared with the group of patients with AUD only on the likelihood of abstinence, the time to first drink, depressive symptoms, and substance use or psychiatric service utilization at 1-year follow-up.

2. Materials and methods

2.1. Procedure

At admission to the residential, abstinence-oriented AUD treatment programs, the detoxified patients completed an intake information form (IIF), which assessed sociodemographic characteristics, indices of substance use and its consequences, psychological and social functioning, number of prior hospitalizations, and prior involvement in outpatient treatment and self-help activities. At discharge, patients completed a discharge information form (DIF), which assessed indices of substance use, psychological and social functioning, and number of individual and group treatment sessions. Diagnoses were based on the guidelines of the *International Classification of Disease,10th Revision* (Dilling, Mombour, & Schmidt, 1991). At the 1-year follow-up after discharge from the index episode, patients completed a follow-up information form (FIF), which assessed identical content areas as the IIF. The assessment instruments used in the IIF, DIF, and FIF are described in greater detail under Section 2.4 (Assessments). Data were collected between 2001 and 2003. The study was approved by the Ethics Committee of Canton Bern (Proposal-Nr: 109/99).

2.2. Patients

All patients with SUDs who entered into 1 of the 12 residential treatment programs with an intended length of stay of 4 months (the index stay) were asked to participate in this study. A total of 805 of 1,088 (74%) patients agreed to participate. Of these, 630 patients had an AUD and 64 of those both AUD and MDD. The inventories at admission, discharge, and 1-year follow-up were completed by 441 patients (70%), with 64 patients (14.5%) having a diagnosis of comorbid MDD, 283 patients (64.2%) having clinically significant depressive symptoms at admission, and 81 patients (18.4%) having clinically significant depressive symptoms at discharge according on the Brief Symptom Inventory (BSI; Derogatis, 1993). The other 13 patients left the programs before detoxification was completed, were not able to participate because of medical conditions or language problems, or refused to participate.

Patients who responded to all three measurements were compared with nonresponding patients on demographic characteristics, substance use, and psychiatric symptoms and diagnoses. Respondents were slightly older than nonrespondents (45.0 vs. 42.9 years; $t = 2.78$, $df = 693$, $p < .05$), were more likely to be married (36.2% vs. 21.7%; $\chi^2 = 15.40$, $df = 1$, $p < .001$), and employed (54.8% vs. 39.6%; $\chi^2 = 14.57$, $df = 1$, $p < .001$). No differences were found for other indices.

2.3. Residential treatment programs for AUDs

We selected 12 standard practice residential treatment programs for patients with AUD to capitalize on realistic treatment conditions and typical treatment orientations so that programs are representative for the German-speaking part of Switzerland. These programs are financed by the Canton and by obligatory public health insurance. Premiums for health insurance are paid for individuals who cannot afford them by the community where they live. Staffing patterns of programs depend on the number of patients but always include psychiatrists, psychologists, social workers, and nurses.

Program characteristics are described in more detail and compared with residential AUD programs affiliated with the U.S. Department of Veterans Affairs Health Care System in two publications by Moggi, Giovanoli, Buri, Moos, and Moos (2010) and Moggi, Giovanoli, Strik, Moos, and Moos (2007). Overall, Swiss programs were five times longer (122 days) than U.S. programs, offered more individual and fewer group sessions, focused on substance abuse, were clearly less 12-step/AA but similarly cognitive–behavioral treatment oriented, and emphasized the disease model less but similarly

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