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CASE STUDY TO ASSESS THE EFFECTIVENESS OF  
COGNITIVE BEHAVIORAL THERAPY  
AND PSYCHOTROPIC MEDICATIONS AS A  
TREATMENT APPROACH FOR AN ADULT MALE  
WITH MAJOR DEPRESSIVE DISORDER  
AND OPIOID DEPENDENCE

by  
Brian Newman

A Thesis

Submitted in partial fulfillment of the requirements of the Master of Arts Degree  
of  
The Graduate School  
at  
Rowan University  
5/1/02

Approved by \_\_\_\_\_  
Dr. Janet Cahill

Date Approved 5/22/02

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## ABSTRACT

BRIAN P. NEWMAN

### CASE STUDY TO ASSESS THE EFFECTIVENESS OF COGNITIVE BEHAVIORAL THERAPY AND PSYCHOTROPIC MEDICATIONS AS A TREATMENT APPROACH FOR AN ADULT MALE WITH MAJOR DEPRESSIVE DISORDER AND OPIOID DEPENDENCE

2001/02

DR. JANET CAHILL  
MASTER OF ARTS IN APPLIED PSYCHOLOGY

The purpose of this case study was to assess the treatment effectiveness of Cognitive Behavioral Therapy (CBT) on a client with a dual diagnosis of major depressive disorder and opioid dependence. The client exhibited severe depressive symptoms along with symptoms of opioid dependence.

The client's depressive disorder was the primary diagnosis on Axis I due to onset of symptoms beginning before substance use began. A review of major studies evaluating Cognitive Behavioral Therapy with depressive disorders and substance dependence was conducted. Studies which evaluated the use of Cognitive Behavioral Therapy as a treatment modality alone and coupled with psychotropic medications were reviewed along with studies comparing CBT with and without medications against other types of treatment modalities. The client was received treatment at a community based program using CBT techniques. The Beck's Depression Inventory (BDI) was administered before and after treatment. Results indicated that CBT was effective treatment for the client in the study with a diagnosis of depression and opioid dependence. Self report and follow-up contacts at three weeks, eight weeks and 14 weeks after discharge also supported the conclusion that the treatment was effective. The need for more research in the area of dual diagnosed individuals and CBT is discussed.

## MINI-ABSTRACT

Brian P. Newman

### CASE STUDY TO ASSESS THE EFFECTIVENESS OF COGNITIVE BEHAVIORAL THERAPY AND PSYCHOTROPIC MEDICATIONS AS A TREATMENT APPROACH FOR AN ADULT MALE WITH MAJOR DEPRESSIVE DISORDER AND OPIOID DEPENDENCE

2001/02

Dr. Janet Cahill  
Master of Arts in Applied Psychology

The case study was conducted to study the effectiveness of Cognitive Behavioral Therapy (CBT) and psychotropic medications as a treatment modality on an adult male with major depressive disorder and opioid dependence. The Beck's Depression Inventory and self-report at follow up were used as outcome measures. The client showed significant improvement in depressive symptoms according to these measures.

## **Acknowledgments**

During the process of completing the Thesis, there have been many people who went for the ride with me. I would first like to thank Dr. Cahill and Dr. Kerwin for assisting me through this process, I learned a great deal about myself. A special thanks to Dr. Chapell for all his assistance and patience and by the way, thanks for the publication. Thanks goes to the Psychology Department, Elaine you have been a God sent to me. There are many people within my life whom deserve praise and thanks for being supportive and caring through these stressful three years. Thank you to the Maryville staff for teaching me when I thought I could no longer learn. Mom, Dad, Jeff, Steven, and Kelli thanks for being supportive and understanding. A special thanks to my parents, with which none of this could be possible. To Jennifer, I give you a special thanks for pushing me to keep going. To my friends: Larry, Judy, Angie, Gina, and Melinda for putting up with me throughout these three years. To John Doe for allowing me to treat him. Thank you to the Boughton family for letting me stress out and special thanks to Ms. Boughton for typing this thing. Last but not least, I would like to give my deepest admiration and gratitude to three incredible ladies who stuck by me through the hard times this past year and still loved me. Kathy, Amanda, and Alexis, thank you for being there and always loving me even though loving me was not always so easy.

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## **Chapter 1: Psychosocial Assessment**

Client:

John Doe

Age:

20

### **Presenting Problem**

Client's presenting problem was Opioid withdrawal. He presented with withdrawal symptoms such as nausea, chills, back pain, lack of appetite and lack of sleep. Client stated he has experienced addiction to one drug or another for the past seven years. John also reported he used drugs to medicate himself when he felt depressed on a majority of occasions. John is unable to maintain consistent employment as a result of his heroin dependence.

John's also reported significant symptoms of depression at intake. He reported that depression has been a major problem for much of his life. He reported feelings of hopelessness. His depression has negatively impacted on several areas of his life, including education, occupation and relationships. His depression has impeded his daily functioning, as evidenced by his lack of motivation and his isolating behaviors. John consistently feels down, so he begins to escape first by isolating and then by using drugs. He also stated he has had a lack of appetite since age 13.

John's mother was interviewed and stated he has been using heroin for the past three years. Client's mother also stated, "He was always down in the dumps." John would stay in his room for, weeks at a time, as reported by his mother. "I tried to get him to get help but he refused." John also has never stayed at a job more than a few months.

No other perspectives on John's problem were available during the initial interview.

### **History of Complaint**

Regarding John's depression, he stated he has struggled with motivation in all areas of his life: education, employment and social. Client stated that the lack of motivation has existed as long as he could remember. He stated that he felt alone and did not really want to go out much when he was young. Starting in 7th grade, John said he had to push himself to attend school every day. He would always feel as if he did not fit in with the rest of the students, so he would isolate himself when not in class. He described feeling hopeless and helpless throughout his school years. John reported having no goals for the future and not caring about his future

Client stated the depressed feelings have been around since age 10. John feels depressed most days, but there are periods of severe depression when he occasionally becomes suicidal. John reported he had no plan or intent to hurt himself. He also had numerous fights with peers in school due to their verbal abuse. John believed that his fights made him more depressed because he considered himself a passive person.



John began to drink beer and smoke marijuana to combat his depressed feelings. His use of substances began at age 13 and has continued to his present age of 20. During these seven years, his use of drugs went from alcohol and marijuana to use of heroin. He stated he would use any drug that was available. As his tolerance grew, the type of drug used changed. John said the change in type of drug used was for economic reasons. He thought, it was cheaper for him to change drugs than spend more money for the same drug in larger quantities.

When John began using heroin, he stopped every other drug he was using. His heroin use preoccupied him for the last three years. John's progression began slowly at 1/4 of a bag at age 17 then to two and three bags at age 18, and up to his current use of 13 bags daily. As his use increased, so did his problems in living. Withdrawal symptoms, when not able to use, began to impede his work performance. He began to miss work until he eventually quit one job and began to work other jobs to support his habit. After working for a time, the heroin use became more of a burden, and John had difficulty sustaining employment. He would not show up to work due to feeling sick or lose jobs due to stealing money or materials from jobs. John would sell the materials or use the money stolen to purchase heroin. There were no charges put against him due to his stealing because his employers would not press charges but would fire him instead.

### **Household Composition**

John lived with his parents and has lived with them since birth. His parents were of Irish Catholic decent. John's father was a 49-year old recovering alcoholic and cocaine addict who periodically smoked marijuana. He owned and managed his own company. John's mother has no known history of alcohol or drug abuse. She was a homemaker. John was the oldest of four children in the family. Client's brothers were 15 years, 12 years, and 11 years of age at intake. Client also had a grandfather living at the home. John reported his grandfather drank alcohol in the home.

### **Development History**

According to reports from client and his mother, he had no significant development problems.

### **Family Relations**

Client reported his relationship with his parents was good, aside from their concern about his use of drugs. He stated, "My mom keeps the family together." John's mom is the main force in the family. John reports his mother is the person who has the ability to diffuse a difficult situation in the household. He denied any sexual or physical abuse. He also denied any emotional abuse within the family.

John stated his family has always been supportive whether it was in school, work or other areas of his life. His father always would help him with school or employment. John's father has employed him consistently, even though John's attendance was sporadic. John

reported a concern about his father's marijuana smoking because of his own struggle with drug dependence. He believes his father should not use any drugs, thereby supporting what John was trying to accomplish in managing his own addiction.

John's relationships with his three brothers was good as reported by John and his mother. He stated he does not want his brothers to turn out like him, so he tells them how bad drug use is. John stated he never gets high around his brothers or family. John believed that he is trying to stop his drug use not only for himself, but also to show his brothers that life is better without drugs.

John began to isolate himself from his family when he began feeling depressed. Even when he was depressed, however, he would always have dinner with the family because it was tradition to have dinner together. John does not report any significant interaction between himself and his grandfather besides an occasional hello.

### **Drug and Alcohol History**

John stated he started to drink alcohol at 13 years old, starting with one beer periodically and progressing to a 30-pack of beer and a pint of liquor daily by age 17. The alcohol was accessible at home and around friends. John also began to smoke marijuana at 13 years old, which began with a few "drags" on a joint and progressed to half an ounce daily. John stated he used alcohol and marijuana to combat the feelings of hopelessness, "I feel better when I can forget."

When John was 16, his tolerance to alcohol and marijuana increased. This led to experimentation with other drugs, such as cocaine, Lysergic Acid Diethylamide (LSD), Methylenedioxymethamphetamine (XTC), crack, Ketamine (Special K) and benzodiazepines. John's use of these drugs was periodic until he found heroin at age 17. His heroin use started at 1/4 of a bag, and increased to 13 bags daily. The use also progressed from snorting the heroin to injecting the drug into his vein. John stated, "Heroin was the answer to my prayers, it made me forget about all my problems." John reported a family history of addiction on his father's side of the family. His paternal grandparents both had addictions to alcohol. John's grandmother died due to cirrhosis of the liver. His grandfather was still drinking. He also had an aunt, from his father's side of the family, who had an addiction to cocaine and alcohol, but has been in recovery for eight years.

### **Psychiatric History**

At the time of admission, his primary presenting problem was heroin withdrawal and depression. John was alert and oriented to time, place and situation. Affect was depressed. He reported having feelings of shame and guilt for what he has done to his family through the years. He also stated he has had low self-esteem all of his life. He denied visual, auditory and olfactory hallucinations. John denied paranoia and delusions. John's memory was good and there was no evidence of a thought disorder. Client's

judgement and insight were poor, as evidenced by his past legal problems and his employment. John's speech was lucid in rate and tone with articulate stream of thought.

John denied current suicidal ideations, but stated that in the past he had suicidal ideations. He had no plan or intent when he was actively having ideations. There was no documented history of suicidal behavior. Client denied any homicidal ideations at intake, but did admit that when someone gets him upset, he has felt like hurting that person. John stated he self medicated his depression, so he did not feel down. Client has had no treatment to deal with his depressive thoughts. John was evaluated by a psychiatrist while at the community-based program and put on Wellbutrin to treat his depression.

There is also a history of psychiatric problems within his family. According to John, both of his grandfathers have depression. The client also has an uncle on his mother's side of the family and an uncle on his father's side that experience depression. He indicated that all members in the family who suffer from depression have been treated by a psychiatrist and received medication. He was unable to elaborate on the type of medications, or if they were currently taking antidepressants.

### **Medical History**

John stated at admission he was recovering from two hernia operations and was unable to lift anything for six weeks. John also stated that he would need to get checked out for possible testicular cancer. He reported his doctor has ordered a CAT Scan, which he will complete upon discharge. John reported no other past or present physical

problems. Client stated he was only receiving ibuprofen for pain when needed due to his surgery. John received no other medications for medical reasons.

### **Education and Employment History**

John reported he dropped out of high school in the 11th grade due to trouble in school. He stated he had trouble with authority and got into many fights in school. John was disciplined by detention and suspensions due to his fighting with other students, disrespecting teachers, and skipping school. Client eventually earned his General Equivalency Diploma (GED) and was in a blue collar job.

He has had difficulty in maintaining employment. He has been able to maintain his current job only because his position is within the family business.

John indicated that he had friends before his depressive thoughts began. He considered these friends to be good friends, but at about age 10, he began to isolate himself from others. John did not see anybody outside the school environment. His relationships after age 10 became non-existent. John also stated he had no friends from any of his jobs. The only people he interacts with are his family.

Client has had two girlfriends. These relationships lasted about a month each. Neither of the relationship progressed past kissing. John has not had any sexual relationships. He stated, "relationships take too much work."

### **Other Agency Involvement**

John has had a long history of legal problems. He stated his problems with authority in school carried over to the police. John has had incidents with the law since age 14. His charges began with six curfew violations from age 14 to age 17. He has also had six underage drinking charges.

As John's addiction increased and his drug of choice changed, his legal charges became more serious. He began to smoke marijuana and was arrested for possession at age 16. Client was also arrested at age 17 for possession of heroin. He stated that when he was arrested, he did not care because he was hoping to go to jail. Client said he would have gotten clean from drugs in jail. John was not put in jail, instead he received probation. At age 17, he was unable, as he stated, to understand the importance of being on probation, so he violated his probation within the year. John denied any current or pending legal charges at the time of interview.

Client was admitted to an in-patient facility for detox services two years ago for opioid dependence, but left the facility Against Medical Advice (AMA). He reported he was not ready to get clean. John stated he felt pressure from his parents to get clean from drugs. John went back to using drugs until a year later, when he was admitted to a drug treatment program for detox and residential services. Client reported he thought he was ready to stop using drugs. He was able to complete treatment, was referred to the Center for Family Services for intensive outpatient treatment. John stated he was only able to

stay away from drugs for one month, and then, due to non-attendance at Narcotics Anonymous/Alcoholics Anonymous, and sporadic attendance at his intensive outpatient program, he relapsed. He stated he was unable to follow through with recommendations. John was readmitted into a residential drug treatment program.

Client stated the only other treatment he received was anger management classes in school due to his numerous fights.

### **Social Supports**

John does not have a supportive social support system outside his family. He only associated with other heroin users. John stated there was not much support from the individuals with whom he used heroin. They just wanted to use his heroin.

John has recently gotten closer to his brothers. He is attempting to get sober to show them life is better without drugs. Client also states he has support from his parents, but he does not open up to them. John stated that he finds it difficult to talk to them about anything important. Although client says he does not talk to his parents about important issues, he considers them his primary support system. Client has not had any relationship with close friends or girlfriends since sophomore year of high school. He reported no interest in developing any intimate or friend relationships.



### **Situational Stressors**

John's primary situational stressors are his consistent use of drugs and his feelings of hopelessness. Another stressor for John is his inconsistent employment history. He is unable to maintain job security due to inconsistent attendance.

Client's withdrawal symptoms were the initial stressor to initiate his admission into treatment. John's lack of motivation and his continuous intake of heroin, were also stressors in his life.

### **Coping Mechanisms**

John had no healthy coping skills. He coped with his depression by using drugs. John had been combating his depression by using alcohol or drugs since age 13. An important identified area of need is John's coping skills. He appears not to know how to cope with his daily issues, such as problems at work, family problems and lack of support outside the family.

One of John's interpersonal strengths is his willingness to continue treatment even after several failures. His need to feel better motivates him to continue trying to stop using drugs. Client is also interested in treating his depression which has hindered his attempts at recovery. John agreed to meet with the psychiatrist for possible medications to treat his diagnosis of depression.

## **Summary**

John is a 20-year old Caucasian male who has an addiction to heroin. He reports he has suffered from depressive thoughts since age 10. According to John he uses drugs to feel better. Client has also socially isolated himself from anybody who does not use heroin.

John's alcohol and drug use interfered in the following major life areas: Physical Health, Social Adaptation, Vocational Development, Educational Achievement, and Psychological Functioning. Evaluation revealed that his physical health was impaired by marked tolerance and the inability to control his use of alcohol and drugs. His social adaptation was impaired, as evidenced by his inability to control his use of heroin, alcohol and other drugs, isolation, lack of friends, no social life and no hobbies. His vocational development was impaired by his leaving high school, inability to hold a job and poor financial status. His psychological functioning was impaired as evidenced by his depressed mood, shame, guilt, low self-esteem and his rationalization of his use and consequences.

## **Assessment**

The assessment was completed using a focused interview with client, review of written documents, records from previous treatment, an Addiction Severity Index (ASI), Beck's Depression Inventory (BDI) and medical evaluation.

These data indicated a variety of strengths, weaknesses, problems and needs for the development of a treatment plan.

The client's strengths were motivation for treatment, good verbal skills, good family support from mother, no current legal problems, and willingness to change his life.

The client's weaknesses are: history of relapse; poor self esteem; isolation; poor employment history; poor attendance at NA/AA meetings; inconsistent follow-up with treatment and recommendations; lack of financial stability; and lack of insight, as evidenced by his continued use of heroin.

John's problems are: inability to abstain from alcohol and drugs; lack of non-using social support system; low self esteem; inability to express emotions appropriately to family; poor work history, and depression.

John's needs are: ability to abstain from drugs and alcohol; coping skills to combat relapse issues; improvement of self image; treatment of depression; introduction and assimilation to Narcotics Anonymous and Alcoholics Anonymous communities; developing meaningful relationships with peers; and stable employment. In order to reduce depressive symptoms he needs to increase his peer contact, work with counselor on Cognitive Behavioral techniques to lower his depressive symptoms and work on increasing his low self-esteem.

## **Chapter 2: Differential Diagnosis**

Axis I:	Major Depressive D/O 296.32 Opioid Dependence D/O 304.00 Opioid Withdrawal D/O 292.0
Axis II:	No Diagnosis V71.09
Axis III:	Hernia 257.9
Axis IV:	Lack of social support Inconsistent employment Numerous legal problems
Axis V:	GAF scale 45

Client meets criteria for opioid withdrawal according to the *Diagnostic Statistical Manual, IV(TR)* Text Revision as reported and demonstrated by the following criteria for opioid withdrawal:

1. Cessation of opioid use that has been heavy and prolonged as evident by his three years of heroin use, which began at 1/4 of a bag and progressed to 13 bags daily.
2. Client's complaint of nausea, vomiting, muscle aches, insomnia, sweating, diarrhea, and client's dilated pupils.
3. John Doe also stated his sickness has kept him from working due to feeling withdrawal symptoms, and his need to use drugs just to function.

John Doe also meets criteria for Opioid Dependence according to the DSM-IV(TR) as evidenced by:

4. Tolerance – client reports his increased use of heroin from 1/4 of a bag to 13 bags daily for past three years.

5. Withdrawal – withdrawal is evidenced by client's complaints of vomiting, diarrhea, chills, nausea, agitation, lack of sleep, and lack of appetite.
6. John reported trying many times to cut down or quit use of heroin, but was unsuccessful.
7. Client reported that getting a bag was time consuming and some times he needed to drive long distances to get it.
8. John stated he was unable to work on a consistent basis due to the need to use drugs just to function at work.

John states he feels depressed most days, and he continues to use to take his depressive feelings away. His symptoms meet criteria for Major Depressive Disorder,

Recurrent according to the DSM- IV TR as seen by:

9. Presence of two or more depressive episodes (criteria For Major Depressive Episode).
  1. States he feels sad or something is missing inside himself on most days.
  2. Client has no interest in things he used to like, such as, sports or dating.
  3. John reports not having an appetite since he was around 13-years of age. He explained, "I would eat very little at each meal."
  4. Client also states he felt tired most days when he would feel depressed.
  5. Stated he always felt worthless to his family, as evidenced by his job with his father's company, where his work attendance was inconsistent.

6. He has also had suicidal ideations in the past. He stated, "I didn't want to live." He reported no plan or intent.
10. John reported no elevated moods or manic episodes, he basically felt low most of the time.

When assessing John's problems and symptoms, you must first rule out certain disorders before making an accurate diagnosis. Schizoaffective disorder must be ruled out before a diagnosis can be made. Client suffers from no hallucinations or delusions, therefore, he does not exhibit characteristics of schizoaffective disorder. Another diagnosis which needs to be ruled out due to the similarities of each disorder, is dysthymic disorder. John does not fit the criteria of dysthymic disorder, as evidenced by the severity of his depressive episodes and the resulting impediment on his usual functioning. The severity of his depressive episodes are evidenced by his mood instability and his feelings of hopelessness, which have kept him in his room isolated for weeks at a time. Substance induced mood disorder is definitely possible due to client's seven-year addiction to drugs. According to John, he began drinking alcohol and smoking marijuana to deal with his feelings of hopelessness and helplessness. Client also stated, "It got me out of myself, so that I could talk to people." Substance-induced mood disorder was also ruled out because John's depressive symptoms began before he began using drugs.

### **Chapter 3: Literature Review**

Because John's primary Axis I diagnosis was depression, a literature review was conducted on the best practice or empirically supported treatments available for depression. It was apparent from the empirically supported literature that Cognitive Behavioral Therapy (CBT) was an effective treatment modality and is a productive mode of treatment. There have been numerous studies examining the effectiveness of CBT as a type of therapy for depression.

This literature review concentrated on individuals with depression. The literature review will focus on: 1) Use of CBT with individuals with depression; 2) The additive effectiveness of psychotropic medications with CBT; and 3) The use of CBT with depressed individuals with substance dependence.

The use of Cognitive Behavioral Therapy for clients suffering from depression originated with Aaron Beck. "Beck hypothesized that depression prone individuals possess negative self-schemata (beliefs), which he labeled the "cognitive triad." Specifically, depressed patients have a negative view of themselves (seeing themselves as worthless, inadequate, unlovable, deficient), their environment (seeing it as overwhelming, filled with obstacles and failure), and their future (seeing it as hopeless, no effort will change the course of their lives)," (McGinn, 2000, p. 257). The person experiencing depression begins, over time, to see only their negative experiences while discounting or ignoring any successful situations. As a result, they maintain their

negative sense of self, which leads to depression. According to the cognitive perspective, the way people interpret specific situations influences their feelings, motivations and actions. Their interpretations, in turn, are shaped, in many instances, by the relevant beliefs that become activated in these situations (Beck, 1993, p. 42). This theory was relevant to the current case in that John has many negative thoughts; he reported using heroin because it takes away his depressive feelings.

A number of studies have empirically examined the effectiveness of CBT. In a study by Briggs, *et al.* (2000), depressed subjects were assigned to one of three conditions, CBT, non-directive counseling and general practitioner care. There were 197 subjects in the study; 137 were able to choose their treatment, and 130 were randomized between only non-directive counseling and CBT. All subjects were administered the Beck Depression Inventory before and after treatment. Subjects that received Cognitive Behavioral Therapy and non-directive counseling improved on the Beck's Depression Inventory (BDI). There was a significant short-term positive effect in the use of Cognitive Behavioral Therapy and non-directive counseling, compared to general practitioner care. However, at 12 months follow up there were no differences between the three conditions. There were also no significant differences found between the CBT and non-directive counseling condition. This study would indicate that CBT was as effective as non-directive counseling as a treatment modality initially, but in the long term is no more effective than general practitioner care. Another study conducted by



DeRubeis, Hollon, Grove, Evans, Garvey and Tausaon (1990), examined the effect of changes in depressive cognitions on depressive symptoms for outpatient adults. These subjects were randomly assigned to either a cognitive therapy condition or pharmacotherapy condition with no CBT. Severity of depression and cognitions were assessed at the beginning, middle, and end of the 12-week study. The cognitive measures were the Attributional Style Questionnaire (ASQ), Automatic Thoughts Questionnaire (ATQ), Dysfunctional Attitudes Scale (DAS), and the Hopelessness Scale (HS). Results on the ASQ, DAS, and HS measures showed improved depressive symptoms from pre-treatment to mid-treatment in both groups, but only the cognitive therapy group showed improvement from mid-treatment to post-treatment. According to the results, both conditions showed significant improvement in symptoms from pre-treatment to mid-treatment on all four cognitive measures. There was a trend for more improvement in the DAS for the CT group compared to the pharmacotherapy condition. Examination of changes in depressive symptoms from mid-treatment to post-treatment showed improvement in scores on the ASQ, DAS, and HS for the CT condition.

The use of Cognitive Therapy and Cognitive Behavioral Therapy alone as treatment for depression has been widely examined, (DeRubeis and Crits-Christoph, 1998; Dobson, 1989, DeRubeis, Hollon, Grove, Evans, Garvey and Tunson, 1990, Reinecke, Ryan and DuBois, 1998). In the meta-analysis by Dobson (1989), he compared 28 studies examining Beck's Cognitive Therapy and its effectiveness on

depressive individuals. Within the 28 studies examined, the degree of change in depressive symptoms for the Cognitive Therapy conditions was compared to other conditions, such as waitlist, control, pharmacotherapy, behavior therapy and other psychotherapies. Dobson (1989), concluded through his meta-analysis that the use of Cognitive Therapy was effective in lowering depressive symptoms according to the Beck Depression Inventory (BDI) as an outcome measure.

CBT has also been evaluated as a treatment approach for depressed adolescents. A meta-analysis by Reinecke, Ryan and DuBois (1998), evaluated the use of Cognitive Behavioral Therapy (CBT) on depressed and dysphoric adolescents. They examined six studies which compared a control condition and CBT at post-treatment and at follow up. The use of self reported improvement of depressive symptoms was the outcome measure of these studies. According to the results of the meta-analysis, the use of CBT for depressive symptoms was effective in the adolescent population studied.

A study done by Rohde, Lewnsohn and Seeley (1999) examined the “impact of pretreatment depression severity and functional impairment on the response of 2 samples of older depressed adolescents to group Cognitive Behavioral treatment and a waiting list control condition.” (Rohde, 1994 p. 851). Subjects were 14 to 18-year old adolescents with a diagnosis of depression. They were randomly assigned to one of three conditions: CBT, CBT with a group for parents or a waitlist condition. There was improvement shown only in one of the samples with the more severely depressed group than with the

control group. CBT was shown as effective compared to the control group and not to the CBT group that received the parent group. There was no difference between the two active CBT conditions. This is another study then, which showed the effectiveness of Cognitive Behavioral Therapy compared to a waitlist condition.

Similar results were seen in a study by Clarke, Rohde and Lewinsohn , (1999), who examined the effects of acute and maintenance Cognitive Behavioral Therapy on depressed adolescents. They, along with Rohde (1994), randomly assigned each adolescent to one of three conditions: waitlist, 14-session group Cognitive Behavioral Therapy, and 14-session group CBT with a separate CBT parent group. Severity of depressive symptoms were assessed by scores on the BDI and Hamilton Depression Rating Scale (HAM-D; Hamilton, 1960) a pre-treatment and post-treatment. “The two active treatment conditions, adolescent group CBT with and without parent involvement did not differ, but both were superior to a waitlist control.” (Clarke, 1999, p. 279).

Shapiro (1994) studied Cognitive Behavioral Psychotherapy versus psycho dynamic-interpersonal psychotherapy when treating 117 depressed adolescent subjects. Each of the 117 depressed subjects were randomly assigned to either 8 or 16 sessions of either Cognitive Behavioral Therapy or psycho dynamic-interpersonal psychotherapy. Again, the Beck Depression Inventory was used as an outcome measure. Both treatment approaches lead to improved scores on the BDI, with the CBT condition having a

marginally greater impact. The differences between the two conditions were not statistically significant.

Kahn (1990) tested three treatments and a waitlist control for sixty-eight adolescents with moderate to severe early stage depression. The adolescents were randomly assigned to the waitlist, Cognitive Behavioral Therapy, relaxation treatment condition, or self-modeling treatment. The three active treatment conditions showed a significant improvement in self image and other depressive symptoms, compared to the waitlist control group according to two self report measures: Reynolds Adolescent Depression Scale (RADS; Reynolds, 1987) and the Bellevue Index of Depression (BID; Petti, 1978).

Another population which has been studied was college women at risk of clinical depression. Peden (2001) tested the long-term effects of a Cognitive Behavioral group intervention in reducing depressive symptoms and enhancing self esteem in college women who are at risk of clinical depression. Outcomes were determined by pre-treatment and post-treatment outcome measures. The measures were the BDI, Center for Epidemiologic Studies Depression Scale (CESD; Radloff, 1977); Crandell Cognitions Inventory (CCI; Hollon, Kendall and Lumry, 1986) for negative thinking and Rosenberg Self Esteem Scale (RSE; Rosenberg, 1965) for self worth. These tests were evaluated to determine changes in depressive symptoms. The study concluded that “the women in the intervention group experienced a greater decrease in depressive symptoms and negative

thinking and greater increase in self-esteem than those in the control group. The beneficial effect continued over an 18-month follow-up period. These findings specifically supported the importance of thought stopping affirmations, for preventing relapse of depression.” (Peden, 2001, p.299).

Another study by Thompson, Gallagher and Breckenridge (1987) showed CBT as an effective therapeutic modality with a geriatric population. This study randomly assigned ninety-one geriatric subjects with major depressive disorder diagnosis to one of four conditions. Subjects were assigned to either behavioral therapy condition, a Cognitive Therapy condition, a brief psycho dynamic therapy condition or control condition. Each subject received 16 to 20 individual sessions of therapy and the control condition had a six-week delay in receiving treatment. Each subject was evaluated on their improvement in depressive symptoms according to scores on the BDI, the Hamilton Rating Scale for Depression (HRSD) (Hamilton, 1967), the Geriatric Depression Scale (Yesavage, Brink, Rose Lum, Huany, Adey, *et al.*, 1983), and the Depression Subscale of the Brief Symptom Inventory (Derogatis & Spencer, 1983). All of the treatment conditions showed an improvement in depressive symptoms compared with the control group. There was no significance in the results and they indicated that CBT was not more effective than other treatments in this particular study.

Based on the literature reviewed, it is clear that CBT is a more effective treatment of depression than no treatment option or waitlist. There is some evidence that suggests

it is superior to other treatments, and other literature suggesting that it is not. There have been some studies showing Cognitive Behavioral Therapy is not effective with the depressed client. For example, some studies already discussed, have shown no significant difference between CBT and other treatments (Dobson, 1989; Clark, *et al.*, 1999; Briggs, 2000). The literature is mixed on the effectiveness of medications as an additive, or replacement therapeutic modality. Currently, many practitioners use a combination of CBT and psychotropic medications. Additionally, there is some evidence that CBT can be an effective treatment for some types of substance abuse. Based upon the literature reviewed then, the best practice for this type of client is still in question.

According to Beutler, Scogin, Kirkish, Schretlen, Corbishley, Hamblin, *et al.* (1987), Cognitive Behavioral Therapy is an effective treatment of depressed elderly subjects. Beutler *et al.* (1987) randomly assigned 56 elderly individuals to one of four conditions: alprazolam support, placebo support, Cognitive Therapy plus placebo support, and Cognitive Therapy plus alprazolam support. The dependent variables consisted of a clinical rating of depression using the Hamilton Rating Scale for Depression (HRSD; Hamilton, 1967), Becks Depression Inventory (BDI; Beck, 1972), a self report of depressive symptoms, a measure of cognitive distortion using the Cognitive Error Questionnaire (CEQ; Lefebure, 1931), and polysomnographic measure of sleep efficiency, (Beutler, *et al.* 1987). The results showed subjects assigned to group

Cognitive Therapy “showed consistent improvement in subjective and sleep efficiency relative to non-group therapy.” (Beutler et al., 1987, p. 550).

Some studies report that the combination of medication and psychotherapy is more effective than either treatment alone (Blackburn, Bishop, Glen, Whalley, and Christie, 1981; Weisman, *et al.*, 1979). An average of two-thirds of individuals willing to take the drug will respond to antidepressant medications. (Greeberg and Fisher, 1989; Rush, 1993). When treating someone with depression, the recommendation is to use pharmacotherapy as the initial treatment. Studies have shown the effectiveness of Cognitive Behavioral Therapy and psychotropic medication with clients with depression. “Controlled studies of reuptake blocker medications (a category that includes the Tricyclic Anti-depressants (TCAs) and selective serotonin reuptake inhibitors (SSRIs), and studies of monoamine oxidase inhibitors (MAOIs) for major depression have found that these drugs shorten the duration of episodes of major depression (Frank, Karp and Rush, 1993; Morris and Beck, 1974)” (Littrell, 1995). A meta-analysis reported the combination treatment only modestly exceeded gains with either treatment alone (Cente, Plutchid, Wild & Karasu, 1986). Moreover, the results of several studies suggested that relapse rates after cognitive therapy are lower than those with antidepressant medications (Evans, *et al.*, 1992; Hollon, *et al.*, 1991) and that Cognitive Therapy may have prophylactic effects in preventing the recurrence of depression after the completion of

treatment (Beck, *et al.*, 1985; Teasdale, *et al.*, 1995). These findings hold in treatment of children and adolescents who are depressed as well.

Rush (1979) looked at Cognitive Therapy and tricyclic antidepressant therapy to treat people with depression. Rush was able to show a significant difference between the two types of therapy. He showed that Cognitive Therapy was more effective in treating depression than tricyclic antidepressants. In another study Cognitive Behavioral Therapy was compared to monoamine oxidase inhibitor, phenelzine, and a placebo (Jarrett, 1990). Cognitive Behavioral Therapy may be as effective in treating a depressed person as medications. The study results showed that more than 50 percent of the subjects receiving either Cognitive Behavioral Therapy or medications improved on the post test of the Becks Depression Inventory and the Hamilton Rating Scale for Depression. There was no significant effect between the two conditions. Other studies have replicated this finding of no statistically significant difference between CBT and medications (DeRubeis *et al.*, 1999). Studies have also been done looking at medication combined with Cognitive Behavioral Therapy (Bernstein, 2000). Bernstein conducted a study where she tested the use of imipramine along with Cognitive Behavioral Therapy against a placebo with CBT. She measured outcomes of depressive symptoms on the BDI and Children's Depression Rating Scale-Revised(CDRS-R; Poznanski, Freeman & Mokros, 1985). The results of this study showed, "imipramine in combination with CBT was significantly



more effective in helping adolescents with anxiety and major depressive disorders return to school and in decreasing depression over the 8-week treatment.” (Bernstein, 2000).

### **Treatment Approaches and Addiction**

According to Riessman and Carrol (1996), there is a difference between a simple type of addiction and a complex type of addiction. “A simple addiction is considered a superficial dependence in that it does not involve physical cravings and withdrawal symptoms when the substance is removed. Complex addiction, however, is a physical and psychological dependency associated with good feelings, loss of control over the addiction, and the compulsion to continue use, despite the consequences” (Riessman 1996). John demonstrates all of these characteristics, therefore, it is likely he has a complex addiction.

There have been studies looking at the effectiveness of CBT with true addictions. Morgenstern (2000) randomly assigned individuals with alcohol dependency to either the CBT condition or an alternative therapy condition. The findings showed no significance of CBT in increasing coping. He concluded that, “Research has not yet established why CBT is an effective treatment for alcohol dependence” (Morgenstern, 2000 pg. 1475).

As mentioned previously, this client has been diagnosed as having depression and comorbid drug dependence. Therefore, literature examining the effectiveness of empirically validated treatments for the treatment of both depression and addictions were reviewed. Cognitive Behavioral Therapy has been clinically proven as a positive

therapeutic approach for people with Major Depression disorder and substance dependence (McGinn, 2000). When someone suffers from an addiction, their belief systems, attitudes, and behaviors need to change. When using Cognitive Behavioral Therapy, there is a focus on changing dysfunctional thoughts, emotions and behaviors.

Marques & Formignoni (2001), tested two formats of Cognitive Behavioral Therapy (individual versus group) on adult alcohol and drug dependant patients. In the study, it was shown that each therapy, individual and group formats, were similarly effective in increasing compliance to treatment and predicting success of the patient.

“During the last two decades, cognitive-behavioral therapies have been considered one of the most effective types of therapy to treat alcohol and other drug-dependent problems. (Mattick & Heater, 1993 as cited in Marques 2001).

Medications have also been used to treat substance abuse. One study with alcoholics, used different types of medications, such as selective serotonin reuptake inhibitors and an opioid antagonist, Naltrexone to decrease cravings in alcoholics and also decrease psychiatric symptoms that are associated with alcoholism (Petrakis, 1997). Some evidence suggests that antidepressants and opioid antagonists may benefit alcoholics who experience co-occurring depression (Cornelius, *et al* 1993).

When examining treatment of a dual diagnosed individual, it is important to use as much treatment as you have at your disposal. Some studies have compared CBT and medications as separate treatment conditions for the dually-diagnosed client. These

studies have evaluated the impact of using these two treatment modalities together. Early studies are conflicting.

Based on the literature reviewed, the best practice in treating an individual with comorbid Major Depression and drug dependence appears to be a combination of psychotropic medications and Cognitive Behavioral Therapy. The preponderance of research points to CBT as an effective way of treating someone with dual diagnosis of Major Depression and opioid dependence, but there needs to be more research conducted to determine if CBT is the most effective treatment modality.

#### **Chapter 4: Normative Practice**

All clients of the residential facility attended five psychotherapy groups a week, 21 lectures a week, seven Narcotics (NA)/Alcoholics Anonymous(AA) meetings a week, and one individual session each week of treatment. Clients were responsible to be involved in both their psychotherapy groups and individual sessions. Clients were educated on the disease model of addiction and introduced to the 12 step philosophy through attendance at NA/AA meetings. Attention to the spiritual side of the individual is also addressed through mass, meditation, and pastoral counseling. Clients at the community based setting view videotapes, attend lectures, and have involvement in therapy sessions designed to deal with the mental, emotional, spiritual, and physical health of each individual.

A requirement of the clients was their involvement in a work therapy group, where they were assigned work tasks through their primary groups. Work therapy was essential for the clients to assist them in skill development for future employment. Some work task consisted of cleaning the group rooms, setting up for group, and working in the cafeteria. Each client completed their work task everyday. Clients also participated in community exercise five times a week, which consisted of a community walk for a half hour a day. There was a mandatory recreational activity scheduled each day for one hour in which all residential clients attended. Recreational activities were: basketball,

volleyball, frisbee, football, and horseshoes. The clients were also accountable for keeping their bedrooms clean and their beds made daily.

While attending therapy sessions, the clients receive therapy which is eclectic. Counselors at the community based setting will use a plethora of therapy techniques and types of therapy to best suit each individual client. The therapy modalities used at the residential setting are: Client Centered, Rational Emotive Therapy, Rational Emotive Behavioral Therapy, Gestalt, Rogerian, Reality, and Cognitive Behavioral Therapy.

When discussing drug and alcohol treatment, the majority of treatment providers in this setting will use rational emotive therapy and client-centered therapy.

## **Chapter 5: Treatment Plan**

Since treatment occurred in an agency specializing in substance abuse treatment, the treatment plan emphasized issues around John's addictive behavior. However, since the depression appeared to be primary in this case, the individual therapy sessions focused heavily on that issue. It was conceptualized that John's substance abuse would not improve unless he became less depressed.

### **Problem 1: Client's need to withdrawal from Heroin**

#### **Short-Term Goals:**

- Safe Detox
- Client will safely withdraw from all chemicals, stabilize vital signs and be able to be transferred to the next level of care

#### **Long-Term Goals:**

- John will understand medical effects of chemical use.
- Client will move into residential treatment and maintain abstinence

### **Treatment Implementation**

John Doe's immediate goal was safe withdrawal from heroin. Client needed to withdraw from the heroin before any other goals would be achieved. For this problem, John Doe was medically monitored throughout his detox. Client was medicated to lower the symptoms of withdrawal from heroin. Client received Cyclobenzaprine 10 mg each day of detox for muscle aches. John received Hydroxyzine 25 mg each day for agitation, Dicyclomine 20 mg each day for abdominal pain, Pseudoephedrine 60 mg for lacrimation or rhinorrhea and Ibuprofen 800 mg for pain and muscle aches. When John Doe would complain of problems sleeping, he would also be given Trazadone 50 mg at night.

During client's detox, he participated in psychoeducational sessions on the effects of chemical use. John was educated on withdrawal symptoms of heroin use, long-term effect of its use, physical effects of use, and the disease concept of addiction. John was given a homework sheet on heroin use which contained questions surrounding his use throughout his life. He was required to complete the handout within the five days he attended detox.

John Doe also completed an advantages-disadvantages analysis concerning his use of heroin. He then discussed this with counselor. He was required to look at the advantages and disadvantages of using and not using heroin. Client stated this homework assignment was difficult because it made him actually look at the pros and cons of his

continued drug use. As stated in a future session, John believed his motivation for maintaining sobriety increased after this assignment.

John participated in the detox program for five days. He was able to safely withdrawal from all chemicals as evidenced by his vital signs, such as pulse, blood pressure and respiration and his self-reported symptoms of withdrawal, such as nausea, irritability, and lack of appetite.

To meet the goal of understanding the medical effects of chemical use, John participated in two educational sessions where he was given handouts on heroin use. Client also met with counselor for individual sessions discussing the effects of heroin use and implications of use of heroin. At the end of detox, John had a better understanding of the impact of chemical use because John correctly completed homework assignments asking questions about heroin and its use. John had a better understanding of chemical use as evidenced by John's not understanding that heroin was cut with benzodiazepines. He became aware of this point and it did seem to affect his understanding of why he feels certain physical symptoms of his withdrawal from heroin.

**Problem 2: Negative Self Concept**

**Short-Term Goals:**

- Increase self-esteem by ability to identify feelings
- Importance of psychiatric medication compliance to achieve abstinence



### Long-Term Goals:

- Maintain self-esteem by expressing himself in appropriate manner
- Acquire skills to express feelings in an appropriate manner

### **Treatment Implementation**

To address goal of increasing self concept, Cognitive Behavioral techniques were used to target incorrect beliefs and thinking, such as John's belief that he is no good. For example, when John would make statement that he was no good, counselor would challenge these thoughts by offering encouragement for being in treatment to better himself. John Doe's thoughts were distorted due to his negative self image. It was observed that this technique was particularly effective because when discussing this incorrect belief, he showed noticeable improvement as evidenced by his appearing much happier, his hygiene had noticeably improved, and his interaction with other clients increased.

In problem 2, John had a negative self concept which included low self-esteem, lack of motivation, lack of self-confidence and feelings of hopelessness. Client was referred to a psychiatrist for evaluation. John was diagnosed with Major Depression and was prescribed Effexor (Venlafaxine), 37.5 mg, once a day. Due to his distorted beliefs, such as statements like "I am no good," through his treatment, the Cognitive Therapy technique implemented was a daily thought record. John began the daily thought record as a method for coping with his negative self concept and his distorted views of why he

uses heroin. There was evidence of a positive outcome from therapy due to self report of client and his apparent symptoms of depression subsiding. Client reported he examined his thoughts and was able to attribute them to the beliefs he has held onto since childhood.

John Doe also believed the use of the Cognitive technique activities scheduling increased his self concept. He completed a schedule by hour to determine what was required of him. The use of the activities scheduling was important for John because, he believed, it kept his mind on something beside his feelings of worthlessness.

**Problem 3: Inability to Abstain from Drugs and Alcohol**

Short-Term Goals:

- Abstinance
- Methods of staying clean

Long-Term Goals:

- Maintain abstinence
- Introduction and participation in Narcotics Anonymous and Alcoholics Anonymous fellowships

### **Treatment Implementation**

Client was transferred to residential treatment and was attending all lectures, groups, and Alcoholics Anonymous/Narcotics Anonymous. Client also attended individual sessions with counselor. Client learned methods of maintaining sobriety while attending residential treatment. John was educated on the disease concept of addiction, and the 12-step philosophy of AA/NA. Client was provided Cognitive Behavioral Therapy techniques when attending individual sessions. John Doe was also responsible to complete homework assignments throughout his stay, given to him during his individual sessions. Client's stay was for three months, including his detox.

When working on John's inability to abstain from drugs and alcohol in problem 3, attendance at psychoeducational lectures, relapse prevention lectures and AA/NA Meetings was essential. John Doe also needed to concentrate on his distorted beliefs and cravings for heroin. The use of the CBT technique of imagery was integral in achieving the goals of problem 3. John has had a difficulty in abstaining from heroin for longer periods of time. He was introduced to role play situations where he had to continue saying no to the drug. The use of role play was also essential in teaching John Doe assertiveness techniques to combat drugs if they are in John's presence. He also viewed films with heroin use in them. After films, he would meet with counselor to de-escalate cravings and look at how his life could be more healthy and productive without the drug in his life. John as also taught relaxation techniques, such as meditation to combat

cravings. This was important for John at discharge because he would no longer be in a protected environment. Through self report at follow up, (three weeks, eight weeks, and 12 weeks), John had maintained abstinence from drugs and alcohol. There was also evidence of achievement of goal due to consistent attendance at intensive outpatient program he was referred to after discharge.

**Problem 4: Isolation from Peers**

**Short-Term Goals**

- Increase socialization with peers
- Involvement in recreational activities with peers

**Long-Term Goals**

- Maintain involvement in recreational activities throughout treatment plan
- Involvement in outside activities after discharge

**Treatment Implementation**

To address the problem of isolation, the behavioral technique of activity scheduling was implemented. When John began to schedule his day, his isolation began to decrease. He was also responsible to meet one new client a day in order to increase his socialization. John was unable to isolate while at the community based program because, beside occasional breaks, he attended a group. His isolation was improved as evidenced by his increased contact with peers, establishment of supportive new friendships at follow- up, and his nomination of peer greeter of all new admissions. Client stated, he

never thought he would be able to develop any healthy relationships, because at the time of admission, he believed he was not worth knowing.

**Problem 5: Inability to sustain consistent employment and lack of living skills**

**Short-Term Goals:**

- John will be educated in finding and maintaining employment
- Client will consistently complete all assigned chores at residence
- John will identify employment opportunities

**Long-Term Goals**

- Client will secure and maintain employment after discharge

**Treatment Implementation**

To treat John's problem of inability to sustain consistent employment, he attended work therapy five days a week and completed his assigned work task.

## **Chapter 6: Outcomes**

Client was given the Beck's Depression Inventory (BDI) (Beck, 1961) upon admission and then at discharge.

Pretest BDI score 35 (Admission BDI)

Posttest BDI score 8 (Discharge BDI)

There is evidence that John Doe improved in terms of his depression according to his scores on the pretest BDI to his scores on the post test BDI. John Doe showed improvement in his depressive symptoms after discharge according to follow up at three weeks, eight weeks, and 12 weeks. His improvement was evidence by his securing a job, education compliance, AA/NA meeting attendance, attendance at his intensive outpatient program, and self report.

## **Chapter 7: Comparison of Best and Normative Practice**

Treatment methods and process were established by identifying and prioritizing problems, along with determining both short- and long-term goals and means to attain goals. When treating a client with an addiction, there needs to be a change in the client's belief system and thought process. If a client thinks the drug is the answer to their problems, and there is no change in that thought, the client will never maintain sobriety. The therapist needs to change the thoughts, attitudes, and behaviors, and due to the need to change these, Cognitive Behavioral Therapy would be appropriate due to the importance in this therapy to change negative thoughts, emotions and actions.

The use of CBT as a therapeutic technique at the community based treatment center was an effective approach for John Doe. The treatment modalities at the treatment center would not have addressed John's depressive symptoms, instead would they would have emphasized his dependency problems. There was more emphasize on John's depressive symptoms when using CBT. The use of CBT coupled with psychotropic medications was the best practice with John Doe's dual diagnosis of Major Depression and Opioid dependence.

## **Chapter 8: Summary and Conclusions**

According to literature, the use of Cognitive Behavioral Therapy for the depressed individual or substance dependence will need more examination. The review of the literature is conflicting and it is apparent that the use of CBT compared with other treatment modalities needs more controlled research. In terms of the current case, according to John Doe's self report and scores on the two BDI's, CBT worked for John.

John Doe's addiction and depression has been addressed through the use of CBT, as well as other treatment modalities available in the program. He continued to improve in his life and believed he will be able to maintain recovery. He also believed, because his depressive symptoms have diminished, he will remain stable. Client believed that as long as his depressive symptoms are suppressed, he will have a better chance of maintaining his recovery.



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