**Cognitive Behavioral Therapy (CBT) in a Depression/Alcohol Use Disorder group: A Qualitative Study**

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**Abstract**

A cognitive behavioral therapy (CBT) depression group was integrated into the treatment of four participants in an alcohol use disorder treatment setting. Semi-structured interviews with the participants were subjected to Interpretative Phenomological Analysis to identify relevant themes. Benefits from the group experience were reported as: peer support, change of thinking patterns, increased levels of confidence and of self-efficacy. This study suggests that depression management, especially in a group format, should be offered more frequently as an integrated part of alcohol treatment due to the benefits experienced by the participants.

Keywords: Alcohol, depression, CBT, groups, Interpretative Phenomenological Analysis, integrated treatment services

**1. Introduction**

Individuals with substance use disorders are two to four times more likely to have major depression than the general population (Gilman & Abraham, 2001; Hasin *et al*., 2005) and often experience greater impairment than individuals with either disorder alone. The life of an individual who is dependent on alcohol is filled with incidents that are demoralising, waking daily with a hangover or with tremor and retching, coupled with amnesia for events of the night before, a sense of inability to face the day ahead and awareness of recriminations at work and at home (McIntosh & Ritson, 2001). Add to this the fact that pharmacological effects of alcohol may produce symptoms of depression more or less directly during periods of intoxication and/or withdrawal (Brown *et al*., 1995). Many people also use alcohol to cope with primary depression. Co-morbid psychiatric diagnoses accompanying alcohol dependency, such as severe cases of anxiety or depression, may have a negative impact on quality of life, and on functioning and ability to respond to treatment (Lubman *et al*., 2007; Saatcioglu *et al*., 2008). Situations involving negative mood states are among the most frequently cited precipitants of relapse across several types of addictive substances (Marlatt & Gordan, 1985). The outcome of treatment for alcohol misuse often relies on motivation or commitment of the patient (McIntosh & Ritson, 2001). However, patients with severe depression may find it hard to engage in this kind of therapy until their depressed mood has lifted.

As mental health services and substance misuse treatment have become increasingly aware of the existence of patients with dual disorders, various attempts have been made to adapt treatment to the special needs of these patients (Lehman *et al*., 1989; Minkoff, 1989; Minkoff and Drake, 1991; Ries, 1993). Three approaches have been taken to treatment: sequential, parallel and integrated. Sequential treatment consists of nonsimultaneous participation in both mental health and substance misuse services, parallel treatment consists of simultaneous involvement and integrated treatment combines elements of both mental health and substance misuse services into a unified and comprehensive treatment program. Ideally, integrated treatment involves clinicians cross-trained in both mental health and substance misuse, as well as a unified case management approach, making it possible to monitor and treat patients through various psychiatric and substance misuse crises (Ries, 1993). Evidence is growing that an integrated model of treatment for mental health and substance misuse problems is superior to parallel or sequential treatment (Mueser *et al*., 2007). However, it is not yet clear that this is also the case for alcohol problems (Baker *et al.*, 2010).

The World Health Organisation has suggested that major depression and alcohol use disorders may require simultaneous treatment (Andrews, 2004), but at present there are few randomised controlled trials on simultaneous delivery of psychological treatment for co-existing depression and alcohol problems. In the United Kingdom, services for joint management for alcohol misuse and depression rarely exist (Weaver *et al*., 1999). Weaver *et al.* (1999) stated that the medical model of psychiatric services, with their recourse to legal compulsion to treat those incapable of making rational health choices, contrasts sharply with the psychosocial orientation of substance misuse services. Moreover, as both services often operate referral criteria that specifically exclude co-morbid patients, liaison alone may be a recipe for buck passing. Lydecker *et al.* (2010) report that treatment is often offered sequentially e.g. treatment for depression following completion of treatment for alcohol; or in a parallel manner during the same timeframe in different settings, by different providers. Difficulties with these interventions include potential for conflicting philosophies and recovery models, multiple locations, and scheduling problems associated with separate appointments (Drake *et al*., 1996). Integrated services would put the burden for resolving potential conflicts on treatment providers rather than patients.

The use of integrated cognitive behavioral therapy (CBT) for co-occurring disorders has been proposed, with evidence for its effectiveness in alcohol and substance dependent adolescents and adults with co-occurring depression in combination with antidepressant treatment (Riggs *et al*., 2007). Brown *et al.* (1997), who studied the effects of 8 sessions of cognitive behavioral treatment for depression plus standard alcohol treatment for people with drinking problems, found that between the 3- and 6- month follow-ups, patients had better alcohol use outcomes on total abstinence, per cent days abstinent and drinks per day than the controls who had only received standard alcohol treatment and relaxation training. Patients seemed to gain a better understanding of depression and the factors that affected their moods, and they viewed the depression coping skills as useful and relevant to their recovery from alcohol dependence. Osilla *et al.* (2009) developed a group-based CBT integrated treatment for depression and substance use disorders and using semi-structured interviews, found that this approach was widely accepted by service users and clinicians. Baker *et al*. (2010) compared the effectiveness of brief intervention, single-focused and integrated psychological interventions for treatment of coexisting depression and alcohol use problems amd found that integrated treatment was associated with a greater reduction in drinking days and level of depression.

The current pilot study evaluated an integrated treatment for alcohol and depression within a community alcohol service and aimed at identifying the beliefs that patients have about the treatment that they are receiving, whether it helped them achieve their individual goals and whether their subjective quality of life has improved. It explores in depth the group experiences of the participants, and the impact the group had on their alcohol use, their psychological and physical wellbeing as well as their quality of life.

Structured interviews deliberately limit the extent to which participants can participate in the process (Smith, 2008). The use of semi-structured interviews facilitates rapport/empathy, allows a greater flexibility of coverage and allows the interview to go into novel areas; it also tends to produce richer data. Smith’s (2008) Interpretative Phenomenological Analysis (IPA) attempts to obtain a detailed story of the participant’s own experience, rather than an objective account. It assumes that participants are experts in their own experiences and can offer researchers an understanding of their feelings, intentions, motivations, and attitudes. IPA also allows the researchers to bring their own expertise to bear on the reflective process of achieving meaning.

**2. Methods**

Participants

The study was carried out in a community alcohol service situated in an area lacking extensive self-support services in the West Midlands. Service users can refer themselves or be referred by other professionals into this NHS service to receive a detoxification in the community. Once the detoxification is complete they are offered an aftercare plan of one-to-one or group sessions for relapse prevention, medical reviews with the psychiatrists and if needed anxiety and depression management as an integrated service by the alcohol counsellor. Four participants completed the first depression management group offered by the alcohol counsellor in the service. They were given pseudonyms for the purpose of the analysis. Alan is a 51 year old gentleman who is married and currently unemployed but looking for work. He scored 27 on the Beck Depression Inventory (BDI). He has been in alcohol treatment for 10 months and is currently alcohol-free. Julie is a 49 year old lady who is divorced and unemployed. She scored 36 on the BDI. Julie has been drink-free for nine months. She lost a child 20 years ago and has been struggling to cope with this ever since. Caroline is a 34 year old lady who is divorced and even though unemployed is going to college and looking for work. She scored 29 on the BDI. Caroline is alcohol-free but has reported a number of lapses during the last months. Her children have been taken away by social services and she is trying to get them back. Karl is a 53 year old gentleman who is divorced and unemployed. He scored 41 on the BDI. He reports to feeling too low to look for work at the moment. Karl reports to have been drink-free but has had two lapses since Christmas. He states he always used to drink a lot but it went out of control when his wife left him. All of the participants had key-workers allocated to them and continued working on their alcohol use on a one-to-one basis with their key-workers for the duration of the depression group. All of the participants had key-workers allocated to them and continued working on their alcohol use on a one-to-one basis with their key-worker for the duration of the depression group. Three out of the four participants had a diagnosis of depression, one a diagnosis of post-natal depression and all four scored high on the Beck’s Depression Inventory (BDI, Beck *et al*., 1961).

Materials

An interview schedule was used to conduct the semi-structured interviews which lasted around 45 minutes each. The interview schedule covered areas of experiences of the group and the techniques taught, the experiences of depression before and after the group, the role of alcohol in their depression, beliefs about the group and the impact it had on them and their alcohol use. The topic list was not designed to be prescriptive, but it was used to ensure that important areas of investigation were not overlooked. Follow-up questions by the interviewer gave each participant the chance to talk about the topic most salient to them

Procedure

Participants’ key-workers discussed the possibility of participating in a depression management group with their clients. They forwarded the names to the group-worker who met with the potential participants to discuss taking part in the group and who identified whether clients were appropriate for the group with the use of the BDI. The group was designed by a consultant clinical psychologist for the adult mental health day services team (Table 1 for group content).

**Table 1**. Group content

After completing the eight sessions of the depression management group, participants were given information about the research project by a member of the research team not involved in the group process. If they agreed to participate, they received appointments for a one to one session one to two weeks after the group where the interviews were carried out. The interviewer was the second author who is a senior nurse in the alcohol team and currently acting team leader. He has a lot of experience of working with this client group but had not met the participants before. With the consent of the participants, the interviews were audio-recorded and later transcribed.

Ethical issues

The study received independent peer review approval from Staffordshire University and ethical approval from the local NHS ethics committee prior to participant recruitment. The guidelines prescribed by the British Psychological Society (2009) and the Health Professionals Council (2009) were used to inform ethical practice throughout the study. After the last session of the group, a colleague of the group worker informed the participants about the opportunity to take part in the research, handed out information sheets and written consent was taken.

Data analysis

The semi-structured interviews that had been recorded and transcribed were analysed using interpretative phenomenological analysis IPA (Smith, 2008). The objectives of the study were to identify what beliefs people have about their experience of the group, and the impact the group had on their alcohol use, their psychological and physical wellbeing as well as their quality of life. This makes IPA the most appropriate approach to use for the analysis. IPA also allows the researchers to bring their own expertise to bear on the reflective process of achieving meaning. IPA emphasizes that the research exercise is a dynamic process with an active role for the researcher in that process. This was also seen as important as the researcher was involved in participants’ treatment by carrying out the group work. The first author had not actually designed the group but delivered it and had been working with three of the four participants on a one to one basis for a number of months around their alcohol use. Meaning in IPA is central, and the aim is to try to understand the content and complexity of those meanings rather than measure their frequency. This involves the investigator engaging in an interpretative relationship with the transcript. Each participant’s transcript was examined in detail before moving on to examine the others, case by case. This follows the idiographic approach to analysis, beginning with particular examples and only slowly working up to more general categorization or claims (Smith, 2008).

In the first stage the transcript was read and re-read by the first author making annotations of interesting or significant things the participant said. Then emerging theme titles were identified when reading the transcript again; these moved the response to a slightly higher level of abstraction. The second author also read the transcripts in detail and monitored the emergent analytic account. The aim was to verify that the analysis had been systematically achieved and was supported by the data. The next step then was to look for connections between the themes that have emerged, and then check the transcript to make sure the connections work for the primary source material. In a next stage, a table of themes was produced listing themes, subordinate themes and identifiers.

**3. Results**

Participant accounts clustered around four main themes:

* symptoms and causes of depression, alcohol use, and the relationship between the two
* beliefs that participants held around their thought patterns and how they believed they had changed since entering treatment
* the importance of peer support
* satisfaction with the group experience.

Depression and alcohol use

Participants had different beliefs around their depression. Karl and Alan reported that it was something they had suffered with for years *‘I was always down. Oh it’s always there’ (Karl)*, and Caroline said she was not sure what exactly started it *‘I think it was a build up to be honest, I think it’s hard to pinpoint an exact time’*. Karl and Caroline described their depression as causing low mood, low motivation, feeling weepy a lot, and Alan said it made him isolate himself from the rest of the world, being angry and frustrated *‘I found that I was becoming very irritable not a very nice person at all really’*. Karl reported he was having suicidal thoughts ‘*I mean I still get terribly depressed. I don’t know, I feel like nothing, I just feel flat...I...I...not so much but I still feel fed up...some days I still feel like topping meself I really do’.*

Caroline and Julie stated that not understanding what depression was and what it was caused by, caused feelings of confusion, shame and guilt, making the depression worse. Alan, Julie and Karl stated they knew the reasons for their depression. Julie reported having suffered from a loss many years ago. Alan and Karl reported that they felt the loss of their relationship caused their depression to start. Karl also reported that it was the amount he had been drinking that caused this break-up.These two participants stated that when they then stopped drinking after they had broken up from their partners, their depression became worse as they no longer had alcohol as a coping mechanism.

It appears that there were a number of conflicting statements around the relationship between alcohol and depression. Karl, Alan and Julie did not acknowledge alcohol causing any part of their depression, mainly they stated that it was losing alcohol as a coping mechanism that started their depression. This shows the vicious circle that participants experience when they suffer from depression and have a drinking problem.

*It just put me up like, I don’t drink no more but alcohol put me up when I was drinking (Karl)*

Caroline, however, admitted that depression caused her to start drinking but that it got worse the more she had to drink

*I think I used it as a crutch erm to lift my depression slightly…but then after I’ve had a drink or the next day I felt twice as bad*

Three participants (Alan, Julie and Karl) reported that the main reason they stopped drinking was the physical problems alcohol was causing them ‘*I medically had to stop drinking’ (Alan).* They had been at risk of dying had they not stopped drinking *‘when I stopped drinking I had to stop drinking because it was killing me’ (Julie)*, and Caroline reported that she stopped due to social services taking her children away. Alan had a relapse over Christmas and only realised drinking was a problem once he had become physically dependent again. Even though participants stopped drinking for othersor due to medical reasons *‘I chose to come off the alcohol because my liver was bad and I wanted to see my grandchildren grow up’ (Julie)*, and reported enjoying drinking, they all reported still being drink free at the end of the depression group. Karl acknowledged alcohol will always be a problem ‘*I was back up to where I was before. It’s always come back. The alcohol never goes away’*, and therefore realising they cannot go back to drinking. Caroline denied alcohol being a problem any longer, and states the only reason she doesn’t have a drink is because of social services.

Beliefs around self and change

Participants reflected on the way they used to think and how this had changed over the last weeks or months. There was an appreciation of the impact that changing one’s thought processes had on one’s mental health. Caroline reported that she now tried to look at events differently ‘*I haven’t been weepy at all and again I started changing the way I think, I think a lot different now’.* Caroline, Julie and Alan said that they now have a more positive outlook on life, which has allowed them to start enjoying daily tasks again. They also reported that they felt that changing their thoughts had a significant impact on their feelings.

*When I was down I would look on the dark side of things and the glass is sort of half empty, not half full sort of thing. I now try and look on the positive things. (Alan)*

Julie, Alan and Caroline reported that through the group they had developed an increased awareness of previous automatic negative thoughts and how these affected their behavior. They stated they had realised that understanding how their thinking was faulty in the past helped them to take control over it in the present.

*I mean the last one, the last group was all about should have been should should, everything in life is just should should, and really there is no should in life cause it’s just a nasty word. It has really helped me change the way I think about it, it has ever such a lot. (Julie)*

All of the participants reported a decrease in hopelessness and helplessness. Alan talked about negative expectations and making false predictions, believing the worst would happen in a situation, but realising this was making him irritable. He reported that this realisation had been achieved through an increased awareness of his thoughts. Participants noticed a change in the way they viewed themselves. Their confidence levels increased and they developed a higher level of self-efficacy ‘*I really want to do this, I want to go in that direction, I want to go the right way, I can’ (Julie)*, believing they can make lasting changes in their lives and that they had the ability and power to do this. Being part of a group and learning to talk to other people who are in the same position helped build confidence levels even further (Karl, Julie and Caroline). Julie discussed the increase in assertiveness skills and self-worth that she attributed to attending the group.

*I feel a lot stronger in myself and I feel I can move forward now. I feel that I can move forward I feel that I can now, I‘m a lot more confident*

Alan, Caroline and Karl reported that they used to see themselves as victims of a problem but that they had now realised that they had the control to change this. They found that they had a more positive self-image than they did before the group. Control over their own thinking was seen as a way to maintain change in the future. Julie talked about not letting herself be dragged down by other people or the depression itself, but to take control over her thinking and actions. All of the participants reported using techniques and coping mechanisms taught in the group. Julie and Caroline reported that the group has allowed them to identify alternative coping strategies in their lives, so that they no longer need alcohol to cope with problems.

*I hope I now have it within myself to stay this way. I’m feeling quite like that I feel quite happy you know. I can’t say that I will never sink back, I hope I won’t and as long as I can keep my thoughts this way (Julie)*

Some statements were made, however, that showed that there were still doubts about the likelihood of succeeding or simply acknowledging that their recovery was a work in progress and they needed to keep practicing the techniques they had learned.

*I’m alright for a little bit then but then I feel low again. I try the exercises, like the breathing exercises and sometimes they work, sometimes they don’t. (Karl)*

The above statement shows that Karl felt that even though there were changes in his thinking processes, his mood was still up and down. He also stated that his depression still gets as bad as before but he was now more able to cope with his mood than he had previously been, and was more able to look into the future.

*I look differently at my life, I can nearly see a future, before I didn’t have that. I didn’t know I had one at all, I just lived from day to day (Karl)*

Alan also often talked about medication, the group or others helping him rather than him taking the responsibility over his recovery.

*I think the medication is...you don’t know what it’s doing and you might feel a little bit...it helps me for myself. It makes it easier to not want a drink...and I think it is the medication and it’s also the group, I think the group has played a big part.*

Alan reported that he was still on an anti-depressant which he was hoping to come off in the future and take control over his mental health himself, through what he has learnt in the group. Alan and Julie talked about the need to be ready for change. They believed they were ready at this point and therefore had been successful in completing the group as well as managing to change their depression and stop drinking.

*I think to be successful at this meeting you gotta be ready, you’ve got to decide that you want to do this, to get anything back from it (Alan)*

Understanding what depression is and where it comes from was reported as part of the reason mood levels had increased for Karl and Caroline.

Peer support and support from families

All of the participants identified that one of the most important benefits they received from the group was peer support. They felt that the ability to exchange ideas with other people allowed them to better understand their own thoughts and feelings. Listening to others allowed the participants to reflect on their own behavior, giving them the opportunity to think about things in a different way.

*Because they have other problems and you can talk about it and you see different things about your problems because they have different opinions and you realise it’s sometimes not a problem. (Alan)*

Listening to others’ advice was seen as of more value by Julie than advice from a professional ‘*the doctor just gives you a pat on the back and tells you to go, so it’s the kind of shared experience that helps’*. Another important aspect of the group was the fact that it helped participants realise they were not on their own. This was especially the case in this group as everyone had problems with alcohol as well as depression. Often people have to attend groups specifically for alcohol or depression and they feel that they are not fully understood by their peers. This helped form a strong group identity.

*Now I know I’m not the only one suffering from depression, that’s very important, do you know what I mean, there’s loads of people like me, recovering alcoholics or alcoholics, there’s others suffering with depression (Karl)*

Participants enjoyed the social aspect of coming to a group, especially as they had been isolating themselves for so long. Julie reported she built connections with the others and created friendships. This could have created a certain level of dependency though, which could prove to be detrimental in the future.

*It’s a friendship…and it’s difficult to let go, and those ties are being severed and like. I’m hoping people are still ok and they’re getting on with their lives. (Julie)*

Alan and Julie found it helpful to give advice and support others, and give others their opinions on how changes could be brought about. They reported they felt a sense of satisfaction from helping others.

*It helps you when you hear other people and you can help them. Because they have other problems and you can talk about it and you see different things about your problems because they have different opinions and you realise it’s sometimes not a problem. (Julie)*

Karl and Julie felt that their confidence increased through attending the group, the sense of achievement they felt overcoming the initial anxiety. They had both come through other groups together and had got to know each other well. The group also allowed participants to compare themselves to the other members of the group which in the case of downward comparison helped them to feel better about themselves ‘*there’s always someone who’s worse off than me’ (Karl).* Alan reported that some of the members of the group who dropped out were not ready and were not as far ahead in their recovery as he was.

Satisfaction with group experience

All of the participants felt that the atmosphere in the group was ‘friendly’ and ‘open’, they felt that it was ‘non-threatening’, they could have a laugh and they were comfortable with each other and the group facilitator. This allowed them to talk to each other openly.

*Yeah and even though we’m talking about things that upset us and things that keep us sad it doesn’t feel like that. (Julie)*

There was a strong sense of connection between the group members due to their shared experiences. Karl initially felt nervous but reported that this anxiety ceased soon after the start of the group ‘*you know we all introduced ourselves at the start and that broke the ice and from then on it just went along nicely’.* Alan stated he came to the group with an open mind, though cautious as it was a new experience which Karl had also talked about ‘*I had my doubts because I don’t normally like things like that*’.

Julie felt safe in the group ‘*I felt that I could talk and that it was confidential and it was said that what’s said in the room stayed in the room’* and she felt able to trust the facilitator. Julie and Alan reported that they couldn’t have talked in the group if the facilitator hadn’t been easy to talk to. They also appreciated that they were able to meet the facilitator before the start of the group which helped lower their initial anxiety.

All participants reported they were satisfied with the content of the group. They stated they had learnt a lot and were able to use the materials at home. Regarding the level of difficulty of the materials they said that they understood everything and if there were any questions, they felt at ease to ask questions ‘*If I dain’t understand I just asked her and she would explain it to me’ (Karl)*

Julie mentioned that the summaries of the previous session at the beginning of the group helped them as they said they often forgot. This could partly be because some of the participants struggled with their memory due to damage caused by alcohol. Caroline, Alan and Karl felt that the amount of sessions and the length of each session were ok. Julie reported she would have liked the sessions to be longer to give them more opportunities to chat among themselves. When asked about difficulties to understand any of the materials, none of the participants reported having struggled. Julie and Karl stated that they did not find the content difficult to cope with but they sometimes struggled with the words used by the facilitator.

*Sometimes the words that were used but then we just asked [the facilitator] what they was and she explained, they were long words that we didn’t know but we always got an explanation and we were ok with that. (Julie)*

All of the participants found the homework useful as it gave them the opportunity to read through the materials again and familiarise themselves with it. Julie and Alan also mentioned using what they learned in the group to support their peers and their family at home. They felt that talking to their family helped them, and the group increased their ability to communicate with their family. They stated that this, and the continued abstinence, helped them build up trust with their families again.

*Talking to my family helps, I’ve never been able to talk to my family about it, talking to them really helps. I’ve actually never been able to speak to them but I now feel better, I feel better myself. (Julie)*

The most commonly mentioned techniques used from the group were how to identify automatic negative thoughts and how to change them, making lists and writing diaries, the activity scheduling and the 10 minute rule ‘*if you can’t do an hour, do ten minutes you know, and then usually you enjoy it’ (Caroline)*. Karl and Julie mentioned struggling with certain techniques. Julie has difficulties with her concentration and finds it hard to work on something for long. Caroline did not think all the techniques were relevant to her and picked the ones she thought were appropriate.

The group was relatively small due to some people dropping out after a few sessions. The remaining participants reported that they did not mind this as it made the sessions more personal and they got more opportunities to talk ‘*we could talk more freely, we could discuss each other’s feelings and thoughts so it was fine’ (Julie).* Even though a larger group would have allowed for more sharing of experiences, all of the participants reported they felt more comfortable in a small group*.* One of the problems that became apparent towards the end of the group was the level of dependency that participants had built up with each other as well as with the group facilitator. Julie, Caroline and Karl had previously, or are still currently working on a one-to-one basis with the facilitator and they have become used to this support. There is often a danger of relapse when this happens. However, Julie and Karl stated they understood support would eventually end and they would cope by themselves.

*I would hate it if I started to sink back down again. Never want to do that again. I won’t have that contact I won’t have [the facilitator] to call do you know what I mean, where do I go like. I hope I now have it within myself to stay this way. (Julie)*

The disadvantage of a group setting could also be that it allows participants to avoid painful, personal issues which could inhibit them from dealing with these issues if they were unresolved. This was mentioned by Julie who also receives one-to-one support in a bereavement service but who reports being more comfortable in the group setting.

*I feel more comfortable and more relaxed in my depression group because it is a group of people, yeah*

**4. Discussion**

This study aimed to identify participants’ experiences of a CBT depression group in an alcohol treatment service, and the impact the group had on their alcohol use, their psychological and physical wellbeing as well as their quality of life. All of the participants described their depression as causing them to use alcohol as a coping mechanism and the depression getting worse after losing alcohol as a way to escape from their problems. It could be that people attending and completing the group were those that had underlying depression that after weeks or months of alcohol treatment was worse than it had been before. All of the participants had stopped drinking before they attended the group or only had the odd drink, but none were still dependently drinking. Most participants who had dropped out of the group had still been drinking when it started. This could have an impact on who should be targeted for depression groups within alcohol services as people still drinking heavily might not have the commitment to attend 9 weeks of group sessions, or if they suffered from depression caused by their alcohol use, they might recover from depression without needing the group and therefore drop out early.

The group appeared to have a positive effect on participants’ moods in addition to the treatment they would otherwise have received. Due to the long waiting lists for psychology services, clients who have become alcohol free but are still feeling low are at risk of relapse as low mood has been shown to be among the most frequent reasons for relapse (Marlatt & Gordan, 1985). If this were to happen, these people would often be refused treatment by psychology services due to their alcohol problem.

The second theme that was identified was the change in participants’ thinking patterns. Three out of the four participants reported that they had learned to recognise how their thinking had been faulty in the past. They stated they were now able to identify when they had automatic negative thoughts and that they had developed mechanisms to cope with these. This was one of the major aims of the group, but is difficult to achieve and not everyone had managed to swap negative thoughts with more realistic ones. However, all of the participants reported an improvement in mood and a better ability to cope with negative emotions. They said that they now had these mechanisms to fall back on if their mood ever worsened again in the future, thereby giving them the skills to prevent future relapses from alcohol. This is consistent with the findings of Brown *et al.* (1997) who reported better outcomes for alcohol and depression for people completing alcohol treatment and cognitive behavioral therapy for depression at the same time. The current study also found that participants reported increased confidence and self-efficacy levels. Participants stated that their confidence had increased through being in a group and being able to share their experiences with others as well as through learning that they could cope with their negative thoughts and increase their well-being by themselves without needing medication. This is consistent with Osilla *et al.*’s (2009) findings that CBT treatment structure built confidence levels and the group process was helpful for learning from each other. Participants made a number of self-motivational statements showing they believed that they could recover and they had the strength to do it by themselves. There appeared to be signs in most participants that they seemed to gain a better understanding of their depression and the factors that affected their moods which was supportive of Brown *et al.*’s (1997) findings.

It had been reported that being able to share ideas and experiences in the group was seen as a positive outcome. The group allowed participants to reflect on their current and past thinking patterns and behaviors and ideas were given by the facilitator and the other group members on how to change some of these patterns in the future. It was seen as beneficial that they were in a group where others struggled with depression as well as alcohol problems which allowed them to form a strong group identity. Realising that other people felt the same helped the participants in their recovery as they realised they were not on their own. There is often an assumption that as soon as the alcohol problem is dealt with, people’s quality of life should necessarily increase. However, if there is underlying depression, quality of life can get worse before it gets better. This was a feeling shared in the group and often not recognised by professionals. Some of the participants also reported that they felt satisfaction from being able to help others. These findings are similar to the findings reported by Osilla *et al.* (2009), who stated that the group process was helpful for learning from each other how to cope with depression and alcohol problems.

All of the participants reported the friendly and non-judgemental atmosphere in the group helped them feel safe and comfortable in sharing their experiences. They found the content helpful and reported the diaries, activity scheduling, list-writing and the 10-minute rule were the most commonly practiced techniques taught in the group. Most participants felt that the amount of sessions, their length and the group size were ok and that they enjoyed doing the homework. Although one participant would have liked longer sessions and they would have liked the support to keep going, they did however show understanding that this was not possible. Two of the participants especially found that the homework was useful to engage their peers and families at home in their treatment. It allowed them to explain what they were going through and was useful for them to help their close ones if they recognised symptoms of depression in them. One of the problems brought up was a difficulty with concentration and memory. This could be partly due to damage caused by alcohol. It is therefore important to adjust content and session length for this particular client group. As some of the participants had been in treatment for almost a year at the end of the group, it became apparent that a certain level of dependency had built up. The participants would need to learn to cope by themselves without being able to rely on frequent sessions with their key-workers. Clients in treatment could receive a number of spaced out appointments to slowly adjust to dealing with problems by themselves.

There are a number of limitations to the study that may affect the generalisability of the results. For example, the number of participants in the study was small, and even though this can be useful when using IPA, future research could look at the generalisability of the findings. The current research was carried out by the group facilitator which may have created bias in the analysis; however, it was helpful to develop an in-depth understanding of what was said and meant during the interviews. Robson (2011) stated that the advantages of carrying out ‘insider’ research included having an intimate knowledge of the context of the study, as well as knowing the politics of the institution. The first author who was also the facilitator of the group had been working with three of the four participants around their alcohol use and depression for a number of months. This had allowed them to feel comfortable in the group with the facilitator which could have had an impact on their evaluation. Julie said ‘*[the facilitator]’s very easy to talk to in the group and I think it makes it a lot easier, I think you’ve got to feel comfortable with that person.’* The fact that the participants knew the researcher might have led to them being careful about criticising any aspects of the group or the facilitator as no negative aspects about the facilitation of the group were mentioned or it could have made them feel comfortable enough to share their honest opinions. It could also have had an impact on the analysis, as the author would probably not have understood the meaning of some of the comments made during the interviews as they related to events in the group or from the participants’ past. The interviews themselves had been carried out by the second author who the participants had not worked with before which may have been more uncomfortable for the participants but the risk of assumptions being made that certain information was already known by the interviewer and therefore not explained in detail was reduced.

It was found that offering integrated treatment for alcohol and depression has a number of advantages. The process can save time and confusion for clients and access to psychological therapies will be easier. Participants reported a number of benefits including increased self-efficacy and confidence, increased mood and better coping techniques and positive impact on their quality of life. Despite the literature supporting the integrated model of care, there has been little evidence of it happening. Due to positive outcomes reported by participants, depression management will be continued to be offered in our services and it could be of benefit to train other professionals in the deliverance of this type of treatment.

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