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## Alcohol use disorder and depression as dual pathology. Case report

### Trastorno por consumo de alcohol y depresión como patología dual. Informe de caso

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#### RESUMEN

**Introducción:** La comorbilidad entre trastorno por consumo de alcohol y depresión —patología dual— conlleva un riesgo suicida elevado y un pronóstico adverso. Este caso es singular por su inicio temprano tras un duelo traumático y por la presentación simultánea de dependencia grave, depresión mayor e intento autolítico. Aporta una estrategia terapéutica dual que combina desintoxicación, farmacoterapia y psicoterapia centrada en el duelo, de escasa descripción en nuestro medio. **Objetivo:** Describir el abordaje diagnóstico-terapéutico de un caso de patología dual (trastorno por consumo de alcohol grave y episodio depresivo mayor) con riesgo suicida. **Presentación del caso:** Paciente masculino con consumo diario de 750 mL de ron, anhedonia, culpa, insomnio e ideación suicida activa, más un intento de suicidio 15 días antes mediante alcohol y diazepam. Las principales preocupaciones del paciente eran la incapacidad para controlar la ingesta y la sensación de vacío. Los hallazgos relevantes incluyeron puntuaciones AUDIT 28/40, Hamilton para depresión grave e Ideación Suicida de Beck de alto riesgo. Los diagnósticos principales fueron trastorno por consumo de alcohol grave, episodio depresivo mayor severo sin síntomas psicóticos y duelo complicado. Las intervenciones consistieron en hospitalización involuntaria, sertralina 50 mg/día, naltrexona 50 mg/día y terapia cognitivo-conductual. A los tres meses el paciente mantenía abstinencia, reducción significativa de síntomas depresivos y reinserción laboral. **Conclusiones:** La patología dual con riesgo suicida exige un manejo concurrente y prolongado. Una intervención centrada en el procesamiento del duelo traumático, con soporte familiar y comunitario, ofrece la mejor probabilidad de recuperación y prevención de recaídas.

#### ABSTRACT

**Introduction:** The comorbidity of alcohol use disorder and depression—dual pathology— carries a high suicidal risk and poor prognosis. This case is unique due to its early onset after traumatic grief and the simultaneous presentation of severe dependence, major depression, and a suicide attempt. It contributes a dual therapeutic strategy combining detoxification, pharmacotherapy, and grief-focused psychotherapy, rarely described in our setting. **Objective:** To describe the diagnostic-therapeutic approach to a case of dual pathology (severe alcohol use disorder and major depressive episode) with suicidal risk. **Case Presentation:** A 27-year-old male patient with daily consumption of 750 mL of rum, anhedonia, guilt, insomnia, and active suicidal ideation, plus a suicide attempt 15 days earlier with alcohol and diazepam. The main patient concerns were inability to control drinking and a feeling of emptiness. Relevant findings included AUDIT 28/40, Hamilton scale indicating severe depression, and Beck Suicidal Ideation scale showing high risk. Main diagnoses were severe alcohol use disorder, severe major depressive episode without psychotic symptoms, and complicated grief. Interventions comprised involuntary hospitalization, sertraline 50 mg/day, naltrexone 50 mg/day, and cognitive-behavioral therapy. At three months the patient remained abstinent, with significant reduction of depressive symptoms and return to work. **Conclusions:** Dual pathology with suicidal risk requires concurrent and long-term management. An intervention centered on processing traumatic grief, with family and community support, offers the best chance for recovery and relapse prevention.

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## INTRODUCTION

Dual pathology – the coexistence of a substance use disorder and another mental disorder – represents one of the greatest clinical challenges in psychiatry. The combination of alcohol dependence and major depression increases treatment resistance, chronicity, and above all, suicide risk <sup>(1, 2)</sup>. Up to 70% of alcoholic patients present comorbid depressive symptoms and nearly 69% exhibit some degree of suicidal risk <sup>(3)</sup>.

The present case is considered relevant for communication for three reasons: a) abrupt onset of alcohol consumption at an age below the national average, linked exclusively to unresolved traumatic grief; b) simultaneous presentation of all three severity axes – severe dependence, major depression, and suicide attempt – from the first evaluation; and c) application of an integrated therapeutic model that concurrently addresses detoxification, pharmacotherapy, and cognitive behavioral psychotherapy focused on grief. This approach is scarcely documented in the Cuban literature and provides evidence on the effectiveness of early dual interventions in young patients with complicated grief <sup>(4, 5, 6)</sup>.

The objective of this report is to describe the diagnostic therapeutic approach to a case of dual pathology (severe alcohol use disorder and major depressive episode) with suicidal risk.

## CASE PRESENTATION

A 27-year-old male patient, mixed-race, single, living in an urban area with his mother, a computer technician on medical leave for an anxiety disorder at the time of consultation, with a personal medical history of appendectomy at age 18. Family history includes his father – deceased from liver cirrhosis in the context of problematic alcohol consumption – and his mother – alive with essential hypertension. No psychiatric disorders are documented in first-degree relatives.

Mental state examination reveals mood self-described as “empty and hopeless”, with active and passive suicidal ideation, partial planning – access to methods – without identified immediate intent. Insight is partial: the patient recognizes alcohol as a problem, but expresses inability to control consumption without therapeutic intervention. No additional abnormalities are identified on complete physical examination.

The patient is referred to the Psychiatry Service of the Juan Bruno Zayas Alfonso Clinical-Surgical Hospital by his family physician. The

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condition began 18 months ago, after the traumatic death of his partner in a traffic accident. According to information from the accompanying person, the patient started progressive alcohol consumption as an emotional coping strategy and to facilitate sleep.

In the last six months, the pattern evolved to daily consumption of approximately 750 mL of rum every 24-48 hours, with development of tolerance – need to increase the dose to achieve the desired effect – and withdrawal syndrome – fine tremor, diaphoresis, anxiety – upon reduction of intake. Concurrently, the patient presents anhedonia, persistent fatigue, feelings of guilt and worthlessness, and insomnia.

In the four weeks prior to consultation, he reports active suicidal ideation with wishes to “disappear”. The severity of the condition was evidenced 15 days before evaluation, when he carried out a suicide attempt by ingesting a toxic amount of alcohol combined with diazepam 10 mg – obtained from a previous medical prescription – requiring emergency department attention without need for intensive care unit.

### **Diagnostic evaluation:**

Laboratory studies (complete blood count, hepatic and renal biochemical profile, ionogram) and chest imaging were performed, all with results within normal parameters. The AUDIT test (Alcohol Use Disorders Identification Test) <sup>(7)</sup> was applied with a score of 28/40 indicating probable dependence, and the Hamilton Depression Rating Scale <sup>(8)</sup> and Beck Scale for Suicide Ideation <sup>(9)</sup> indicated severe depression and high suicidal risk, respectively.

The diagnoses established according to DSM-5-TR and ICD-11 criteria were: 1) severe alcohol use disorder (F10.20), 2) severe major depressive episode without psychotic symptoms (F32.2), and 3) complicated grief (Z63.4).

Other diagnoses considered were post-traumatic stress disorder (ruled out because intrusive symptoms did not meet full criteria) and borderline personality disorder (ruled out by absence of a persistent pattern of interpersonal instability and impulsivity prior to the grief).

### **Therapeutic intervention:**

Immediate action, given acute suicidal risk and severe dependence, was involuntary hospitalization in a specialized unit for medically supervised detoxification, psychiatric stabilization, and

psychotherapy. Pharmacological follow-up was also established with selective serotonin reuptake inhibitors (sertraline 50 mg tablet) and aversive agents (naltrexone 50 mg tablets) for depression and alcohol use disorder, respectively.

Regarding psychotherapy, individual cognitive-behavioral therapy focused on grief processing was indicated, two sessions per week during hospitalization, with outpatient continuation, plus group relapse prevention sessions. Family intervention with psychoeducation on dual pathology and crisis management was performed before discharge.

### **Follow-up and outcomes:**

The patient completed 15 days of hospitalization. At discharge he maintained complete abstinence, euthymic mood, denied suicidal ideation, and showed full insight. At three months he continued abstinent (confirmed by self-report and family control), regularly attended psychiatric and group psychotherapy appointments. He returned to his work activity. Treatment adverse effects were mild (initial nausea with sertraline that resolved in 10 days, transient drowsiness). No serious adverse events or readmissions were recorded. Adherence was assessed through attendance records and family report, with complete compliance.

**Informed consent:** Written informed consent was obtained from the patient for publication of this case, guaranteeing the confidentiality of his personal data by removing identifiers.

### **DISCUSSION**

Dual pathology carries a poorer prognosis than each disorder separately, especially when there is a history of a suicide attempt<sup>(10)</sup>. In the present case, the conjunction of severe alcohol dependence, major depression, and high suicidal risk constituted a clinical emergency that demanded an integral and simultaneous intervention.

The use of this simultaneous dual approach showed important strengths: it avoided decompensation that can occur when treating only the addiction (which could exacerbate depression) or only the affective sphere (which could precipitate relapse into consumption). Moreover, the use of validated instruments (AUDIT, Hamilton, Beck) and the inclusion of psychotherapy allowed the severity to be objectified and the evolution from the acute phase to be monitored. This study does not escape limitations: it is a single case, which prevents generalizing the results, and follow up is limited to three

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months, when long term observation is required to assess consolidation of abstinence and complete resolution of grief.

From a pathophysiological perspective, the self medication model explains how the patient resorted to alcohol to modulate the emotional pain of grief, generating a vicious cycle in which the substance progressively aggravated depressive symptoms and hopelessness. Data from González de Armas et al. <sup>(11)</sup>, and Zizzi et al. <sup>(12)</sup> show that 70% of patients with alcohol dependence present comorbid depression, a figure that coincides with this case. However, the uniqueness lies in the age of onset (27 years, well below the peak of 41-50 years) and the clear traumatic trigger, which forced complicated grief to be placed as a priority therapeutic focus.

Regarding the efficacy of the integrated approach, scientific evidence supports the implemented therapeutic strategy. Abstinence based treatment prospectively improves psychological symptoms <sup>(12)</sup>, while the integrated model – combining pharmacotherapy and psychotherapy from the stabilization phase – demonstrates superiority over sequential approaches. Komischke Konnerup et al. <sup>(13)</sup> document the efficacy of grief focused cognitive behavioral therapies in reducing depressive symptoms and preventing relapse in patients with traumatic losses. In their meta analysis, the combination of exposure and cognitive restructuring techniques achieved significant improvements, which supports the strategy described here.

Likewise, Bighelli et al. <sup>(14)</sup> and Bernal García et al. <sup>(15)</sup> found that abstinent alcoholic patients showed lower levels of hopelessness and impulsivity than active drinkers, which coincides with the favorable course observed after detoxification in this patient.

This case report has several methodological limitations. First, its single case design prevents generalization of results to other patients with dual pathology, as it lacks a control group and does not allow definitive causal relationships to be established between the interventions and the observed evolution. Second, follow up was limited to three months, a period insufficient to assess consolidation of abstinence, possible late relapses, or complete resolution of complicated grief. Third, adherence assessment was based on patient self report and family control, without objective measures, which could have overestimated therapeutic compliance. Fourth, the lack of blinding in the application of the scales and in the psychotherapeutic intervention introduces possible evaluation bias. Finally, as this is a case from a single hospital center, the results may not be extrapolable to other contexts. Despite these limitations, the present

report provides a detailed and ethically rigorous description of a complex case, which can serve as a basis for future studies.

## CONCLUSIONS

This case illustrates that the triad of severe alcohol use disorder, major depression, and suicidal risk requires integrated and simultaneous management. The combined approach of detoxification, dual pharmacotherapy (sertraline and naltrexone), and grief-focused cognitive-behavioral psychotherapy stabilized the patient, eliminated suicidal ideation, and maintained short-term abstinence. The main lesson is that complicated grief must be considered a central therapeutic target in these patients, and that coordination between hospital and community levels is essential for relapse prevention and functional recovery.

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**AHD:** Conceptualization, investigation, data curation, methodology, visualization, writing of the original draft, as well as review and editing of the final manuscript.

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