



CLINICAL PSYCHOLOGY AND DEPRESSION ASSOCIATED WITH ADDICTION: A SCIENTIFIC APPROACH

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Author: Adenise de Souza de Oliveira

Graduated in Psychology, from UNESC, Integrated Colleges of Cacoal

Summary:

This scientific article proposes an in-depth approach to the relationship between clinical psychology, depressive disorders, and substance dependence, from a strictly scientific perspective. Based on classical and contemporary psychological theories, as well as empirical studies conducted up to 2021, the article analyzes how the links between depression and addiction are established, the validated treatment options, and the role of the clinical psychologist in this therapeutic process.

Keywords: Clinical psychology; Depression; Addiction; Mental disorders; Psychological therapy.

Abstract:

This scientific article presents an in-depth approach to the relationship between clinical psychology, depressive disorders, and addiction to psychoactive substances, from a strictly scientific perspective. Based on classical and contemporary psychological theories and empirical studies up to the year 2021, the article analyzes how the links between depression and addiction are established, what validated treatment forms exist, and the role of the clinical psychologist in the therapeutic process.

Keywords: Clinical psychology; depression; Addiction; mental disorders; Psychological therapy.

1. THE ASSOCIATION BETWEEN DEPRESSIVE DISORDERS AND SUBSTANCE USE: A DIAGNOSTIC PERSPECTIVE

The coexistence of depression and addiction is a widely recognized phenomenon in the scientific literature on clinical psychology. Estimates indicate that more than 30% of people diagnosed with substance use disorders also experience significant depressive symptoms (Regier et al., 1990). This comorbidity poses a clinical challenge, as both conditions can feed off each other, complicating prognosis and treatment adherence.

From a diagnostic perspective, identifying overlapping symptoms requires technical skill on the part of the clinical psychologist. Many patients seeking help for addiction fail to recognize or mention their depressive symptoms, which can delay appropriate intervention. Furthermore, the neurochemical effects of substances such as alcohol, opioids, and stimulants can mask or intensify depressive symptoms, confusing the initial diagnosis.

The DSM-5 (APA, 2013) includes specific criteria to differentiate substance-induced disorders from primary mood disorders. This distinction is crucial for proper treatment targeting. An accurate diagnosis, based on structured clinical interviews and validated scales, is the first step toward effective comorbidity management.

Clinical psychology has several diagnostic tools for this purpose, such as the Structured Clinical Interview for the DSM (SCID) and the Beck Depression Inventory (BDI), which help quantify the severity of depressive symptoms and identify behavioral patterns consistent with chemical dependency. These instruments increase diagnostic accuracy and allow for more effective and personalized interventions.

The causal link between depression and addiction is still under study. Some studies suggest that substance use may be a form of self-medication to cope with untreated depressive symptoms (Khantzian, 1997). Other studies show that chronic use itself alters brain structures linked to mood, such as the limbic system, favoring the onset of depression.

It's important to emphasize that the order of symptoms directly influences the therapeutic plan. When depression is primary, treatment should address the mood disorder before addressing withdrawal. When it's secondary to substance use, detoxification can lead to partial or complete remission of depressive symptoms, modifying the psychological intervention.

This diagnostic complexity requires a highly qualified professional with solid training in psychopathology and clinical assessment, as well as experience in contexts of psychological vulnerability. By recognizing these nuances, the clinical psychologist becomes a key player in the patient's recovery journey.

2. THE THEORETICAL FOUNDATIONS OF CLINICAL PSYCHOLOGY IN UNDERSTANDING COMORBIDITY

Clinical psychology, as a well-established scientific field, offers different theoretical models for understanding the relationship between depression and addiction. The psychoanalytic perspective, for example, understands substance use as an unconscious attempt to cope with unresolved internal anxieties and conflicts, often rooted in childhood and early object relations (Freud, 1920). Depression, in this context, emerges as an expression of symbolic loss, while addiction functions as an escape mechanism.

In the cognitive-behavioral model, comorbidity is interpreted as the result of dysfunctional schemas that lead the individual to interpret everyday events negatively, generating feelings of hopelessness, helplessness, and worthlessness (Beck et al., 1979). The

Substance use appears as a learned behavior of emotional avoidance, which temporarily relieves suffering but reinforces the depressive cycle.

The humanistic-existential approach, in turn, focuses on existential emptiness and loss of meaning as central elements in both depression and addiction. Authors such as Viktor Frankl (1969) emphasize that a lack of purpose can lead to deep depressive states, in which substance use emerges as an attempt to fill this void. This perspective, although less technical, contributes to understanding the subjectivity involved.

The biopsychosocial model, widely adopted in contemporary clinical practice, integrates biological, psychological, and social factors as determinants of mental illness. It recognizes that genetic predispositions, trauma, dysfunctional environments, and individual vulnerabilities act together in the genesis of depression and drug addiction (Engel, 1977). This model favors broader, more contextualized interventions.

In addition to these approaches, clinical psychology relies on empirical evidence that reinforces its theoretical foundations. Longitudinal studies show that patients with a history of emotional abuse and neglect are more likely to develop depressive disorders and resort to substance use as a means of emotional regulation (Widom et al., 1999).

Integrating these perspectives into the psychotherapeutic process is essential for successful treatment. By understanding the theoretical complexity underlying the comorbidity between depression and addiction, the clinical psychologist can choose more effective intervention strategies tailored to the patient's individual needs, respecting their life story and internal resources.

In summary, the theoretical foundations of clinical psychology not only explain the origin and development of comorbidity, but also support evidence-based therapeutic practice, promoting greater effectiveness in the treatment and recovery of the suffering individual.

3. PSYCHOSOCIAL EFFECTS OF COMORBIDITY: IMPACTS ON LIFE

DAILY LIFE AND INTERPERSONAL RELATIONSHIPS

The simultaneous presence of depression and addiction profoundly interferes with interpersonal relationships, occupational life, and self-care. Individuals with this comorbidity tend to exhibit social withdrawal, difficulties with emotional communication, and distrust in relationships, factors that compromise the stability of family ties.

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The emotional changes caused by depression, such as irritability, hopelessness, and lack of energy, combined with the neurochemical effects of substances, exacerbate interpersonal conflicts. Clinical studies show that couples in which one partner has a comorbidity have a higher incidence of episodes of violence, abandonment, and emotional dependence (Moos & Moos, 2000). Dysfunction in the family nucleus, in turn, exacerbates the individual's isolation.

In the workplace, the consequences are also significant. Reduced productivity, absenteeism, and maladaptive behavior with colleagues and superiors make the workplace challenging. Many patients report a history of multiple layoffs, academic failures, and difficulty concentrating, which contributes to worsening negative self-image and perpetuates the cycle of relapse.

Social exclusion is another significant factor. Society often interprets behaviors linked to addiction as a character flaw, disregarding the clinical aspects involved. This stigma hinders access to treatment, reduces available social support, and contributes to worsening depression (Corrigan & Watson, 2002).

From a psychological perspective, comorbidity impairs the formation of personal identity. The individual's self-perception is compromised, leading to the belief that change is impossible. This learned hopelessness, described by Seligman (1975), reduces motivation to seek help and compromises adherence to therapeutic approaches.

Another significant impact is on self-esteem, often weakened by accumulated failures, external judgments, and a history of trauma. Clinical therapy must work to reframe these events, reconstructing a more functional and realistic narrative about oneself. This reconstruction requires time, a solid therapeutic bond, and techniques tailored to the patient's uniqueness.

Understanding these psychosocial effects by the clinical psychologist is essential to developing a therapeutic plan that goes beyond the symptoms. By focusing on the individual's reintegration into social, emotional, and productive life, treatment becomes more effective and promotes greater autonomy, one of the main goals of evidence-based psychology.

4. CLINICAL INTERVENTIONS IN PSYCHOLOGY: APPROACHES PROVEN FOR COMORBIDITY

Given the complexities involved in the association between depression and addiction, psychological treatment requires integrated, evidence-based interventions. Cognitive Behavioral Therapy (CBT) is one of the most widely used in this context, with solid scientific evidence in several randomized clinical trials. CBT works to restructure dysfunctional thoughts and teaches healthy coping strategies to replace self-destructive patterns related to substance use (Beck et al., 1979).

In addition to CBT, Motivational Interviewing has proven effective in increasing patient engagement, especially in the early stages of treatment. This approach, centered on acceptance and valuing the individual's autonomy, helps reduce resistance to change and strengthen internal motivation. Research such as that by Miller and Rollnick (2002) demonstrates its relevance for populations with a history of frequent relapses.

Another important technique is Acceptance and Commitment Therapy (ACT), which, although more recent, has shown promising results. Based on relational frame theory, it aims to promote greater psychological flexibility, helping the patient live with thoughts and



difficult emotions without resorting to substance use as a form of avoidance (Hayes et al., 1999).

Brief psychodynamic psychotherapy can also be used, particularly for patients with an introspective profile and a history of relational trauma. This approach focuses on the unconscious patterns that maintain the cycle of comorbidity, offering the patient a space to process painful emotional experiences and reorganize their identity.

At the institutional level, clinical psychology can be integrated into multidisciplinary programs that include psychiatry, social work, and therapeutic education. This integration fosters a holistic view of the patient and broadens the scope of interventions, enabling support in different spheres of the individual's life.

It is essential that clinical psychologists have ongoing training, professional supervision, and up-to-date scientific knowledge to apply these approaches ethically and effectively. The combined use of techniques, adapted to each patient's motivational stage and profile, significantly increases the chances of therapeutic success.

By creating a space for empathetic listening, the professional contributes to strengthening the therapeutic bond, which in itself represents a protective factor against relapse. Recognizing psychological pain and validating subjective experience are elements that support the healing process, giving clinical psychology a central role in addressing comorbidity.

5. THE ROLE OF THE CLINICAL PSYCHOLOGIST IN PREVENTING AND PROMOTING MENTAL HEALTH

The role of a clinical psychologist goes beyond intervention in critical moments. They play a strategic role in preventing psychological distress and promoting mental health, especially in populations vulnerable to developing comorbidities such as depression and addiction. Early identification of risk signs, combined with preventive intervention strategies, can prevent the worsening of clinical conditions.

In school, community, and institutional settings, psychologists work to promote emotional education, strengthen self-esteem, and develop social skills. Evidence-based prevention programs, such as Life Skills Training (Botvin & Griffin, 2004), show that fostering interpersonal skills significantly reduces early substance experimentation.

Qualified listening is one of the most powerful tools in preventive practice. By providing a safe space for expressing emotions and conflicts, the psychologist helps the patient process traumatic experiences, minimizing the risk of seeking compensatory psychoactive substances. This active listening strengthens the therapeutic bond and expands the emotional support network.

Another essential aspect is the destigmatization of mental disorders. Psychologists play an active role in raising social awareness about the clinical nature of comorbidity, combating prejudice and promoting inclusion. Reducing stigma facilitates access to mental health services and contributes to treatment adherence.

Furthermore, psychologists can work alongside public health teams and in public policy, promoting community interventions that reach socially vulnerable groups. The integration of clinical psychology into the Unified Health System (SUS) in Brazil and community services in the United States exemplifies how this approach can positively impact public health.

The psychologist's ethical and technical training is a fundamental pillar of this practice. Clinical supervision, a commitment to scientific updating, and adherence to the principles of the Psychologist's Code of Professional Ethics ensure the quality of care provided and the protection of patients' rights.

In short, mental health prevention is a shared responsibility, and clinical psychologists occupy a privileged position in this process. Their work is essential to building a healthier, more empathetic, and resilient society, capable of offering alternatives to suffering before it becomes pathological.

6. THE IMPORTANCE OF CONTINUOUS THERAPEUTIC MONITORING IN MAINTAINING RESULTS

The effectiveness of therapeutic interventions in patients with comorbid depression and addiction is directly linked to the continuity of psychological treatment over time. Maintaining the therapeutic bond, even after partial or complete remission of symptoms, is essential to prevent relapse and strengthen the emotional and behavioral acquisitions gained during the process.

Longitudinal studies show that patients who remain in psychological treatment for periods longer than six months have lower rates of relapse into substance use and greater emotional stability (Hser et al., 2001). This occurs because the continuous therapeutic process allows for the constant reassessment of dysfunctional patterns, as well as the adaptation of strategies to meet the demands of daily life.

Counseling also fosters the creation of a welcoming and reflective space, where the patient can develop self-awareness and autonomy. The opportunity to verbalize anxieties, frustrations, and achievements strengthens resilience and contributes to the internalization of emotional skills that previously depended exclusively on the therapist.

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Furthermore, treatment continuity allows the psychologist to observe the long-term effects of applied interventions, adjusting therapeutic approaches according to the evolution of the clinical condition. This methodological flexibility is especially relevant given the cyclical and multifactorial nature of mental and addictive disorders.

Another crucial point is monitoring risk factors. Often, stressful life events or changes in the family and professional environment can reactivate depressive symptoms or addiction-related impulses. The constant presence of a therapist provides emotional support and prevents the condition from worsening.

Therapeutic maintenance also relates to the concept of responsible discharge. It's not just about ending treatment when symptoms disappear, but also about ensuring the patient is prepared to deal with future challenges in a healthy and independent manner.

This process requires planning, gradual monitoring and, sometimes, spaced meetings as a form of transition.

In short, continuous therapeutic monitoring should not be seen as an unnecessary extension, but as an integral part of a clinical approach committed to the patient's sustainable recovery. It represents the consolidation of psychological care, contributing to the long-term maintenance of mental health.

7. ETHICAL CHALLENGES AND LIMITS OF CLINICAL PRACTICE IN THE FACE OF COMORBIDITY

The clinical psychologist's role in treating comorbid depression and addiction involves complex ethical challenges, requiring technical discernment and a commitment to the principles of autonomy, beneficence, and non-maleficence. The first ethical tension arises when the patient exhibits poor adherence to treatment or expresses a desire to discontinue it, despite the severity of the clinical condition.

In these cases, professionals must balance respect for autonomy with the duty to protect the patient's health, especially when there is an imminent risk to life or physical integrity. Clear communication and building a solid therapeutic alliance are fundamental strategies for dealing with these situations without resorting to coercive or punitive approaches.

Another challenge is confidentiality in settings where the patient is placed in institutions, such as rehabilitation clinics or public health services. The psychologist must carefully manage the information shared with the multidisciplinary team, ensuring the confidentiality of sensitive information, except in cases where the breach of confidentiality is authorized by the code of ethics and is justified to protect the safety of the patient or third parties.

Moral judgment regarding a patient's behavior is a constant risk. Psychologists' training should prepare them to embrace suffering without reinforcing social stigmas associated with addiction, such as the idea of weakness or irresponsibility. Clinical listening requires neutrality and empathy, essential conditions for ethical and transformative action.

The therapeutic relationship can also be affected by intense transferences and countertransferences, especially in patients with a history of rejection, abandonment, or violence.

Recognition of these phenomena and constant clinical supervision are protective measures for both the patient and the therapist, avoiding inappropriate reactions or distortions in the bond.

Psychologists must also respect the limits of their practice, referring patients to other professionals when necessary, such as psychiatrists, social workers, or occupational therapists. Interdisciplinarity strengthens comprehensive care and expands treatment options, as long as each professional works within their technical expertise.

Therefore, clinical practice with patients with comorbidities requires ethical sensitivity, technical knowledge, and a posture of constant reflection. A commitment to human rights, valuing individuality, and respecting the dignity of patients are values that underpin a truly transformative and responsible psychology.

8. FINAL CONSIDERATIONS

Clinical psychology plays an essential role in understanding and addressing the complex comorbidity between depression and addiction. Through diverse theoretical approaches, supported by empirical evidence and structured clinical practices, it is possible to effectively intervene in the psychological processes that maintain this pathological cycle. The clinical psychologist's role goes beyond simple symptomatic management, offering ongoing support, empathic care, and strategies for reframing experiences.

The evidence presented throughout this article indicates that the association between depressive disorders and substance dependence is multifactorial and demands an integrative approach. Effective treatment requires active listening, accurate diagnosis, application of validated techniques, and longitudinal monitoring. It's not just about eliminating harmful behaviors, but also about promoting a process of psychological, relational, and social reconstruction.

The psychosocial impact of this comorbidity directly affects individuals' quality of life, family relationships, occupational performance, and physical health. Clinical psychology, by working at the interface of these domains, can produce significant and lasting transformations, promoting greater autonomy and resilience.

It is also essential to recognize the ethical challenges and limitations of this practice. Commitment to the principles of the Code of Professional Ethics, ongoing supervision, and continuing education are essential conditions for ensuring the integrity of clinical practice. In adverse contexts, the psychologist must maintain a humanized, technically and politically committed stance.

Continuing therapeutic monitoring, even after symptoms have subsided, is essential for consolidating results. Furthermore, investing in preventive measures, especially for vulnerable populations, can reduce the incidence of severe cases and expand access to mental health care.



By remaining aligned with the principles of science, clinical psychology reaffirms its role as an agent of subjective and social transformation. It is through this commitment that it consolidates itself as a fundamental ally in the fight against psychological suffering and the promotion of human well-being.

Thus, it is concluded that the clinical approach to comorbidity between depression and addiction cannot be superficial or decontextualized. It requires sensitivity, scientific rigor, and ethical consideration. And, above all, it requires recognizing psychological pain as legitimate and worthy of care.

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