The International Journal of Indian Psychology
ISSN 2348-5396 (Online) | ISSN: 2349-3429 (Print)
Volume 13, Issue 2, April- June, 2025
DIP: 18.01.171.20251302, DOI: 10.25215/1302.171
https://www.ijip.in

Case Study

Navigating Dual Challenges: Treating Depression and Alcohol Use Disorder in a Policeman

Ms. Khushi Gupta[1]*, Dr. Roopali Sharma[2]

ABSTRACT

This case study explores the intersection of Major Depressive Disorder (MDD) and Alcohol Use Disorder (AUD) in a 45-year-old law enforcement officer, Mr. AB, whose mental health struggles were exacerbated by occupational stress, financial instability, and societal stigma. Comorbid MDD and AUD, prevalent among high-stress professions, create a complex interplay of psychological distress and maladaptive coping mechanisms, necessitating an integrative treatment approach. Using the biopsychosocial model and evidence-based interventions such as Motivational Interviewing (MI), Cognitive Behavioral Therapy (CBT), pharmacotherapy, and family involvement, this study highlights the efficacy of a tailored, multidisciplinary strategy. Over 12 weeks, Mr. AB demonstrated significant improvement in depressive symptoms, alcohol consumption, and overall functioning, underscoring the critical role of holistic and patient-centered care for individuals in high-risk occupations.

Keywords: *Major Depressive Disorder, Alcohol Use Disorder, comorbidity, law enforcement mental health, biopsychosocial model, Motivational Interviewing, Cognitive Behavioral Therapy, pharmacotherapy, family involvement, occupational stress*

Major Depressive Disorder (MDD) is a prevalent mental health condition characterized by persistent sadness, loss of interest in activities, and significant impairment in daily functioning (American Psychiatric Association [APA], 2013). MDD affects approximately 5% of the global adult population annually, with risk factors including genetic predisposition, adverse life events, chronic stress, and comorbid physical illnesses (World Health Organization [WHO], 2023). On the other hand, Alcohol Use Disorder (AUD) is a chronic condition marked by an impaired ability to control alcohol consumption despite adverse consequences, with biological, psychological, and social factors contributing to its onset and maintenance (APA, 2013).

The co-occurrence of MDD and AUD, a phenomenon known as comorbidity, is common, with studies indicating that nearly 30% of individuals with MDD also meet the criteria for AUD (Kessler et al., 2003). This dual diagnosis can create a vicious cycle where alcohol use exacerbates depressive symptoms, while depression drives individuals toward alcohol as a maladaptive coping mechanism (Grant et al., 2015). Comorbid MDD and AUD significantly

[1]Student, Integrated B.A. - M.A. (Clinical Psychology), Amity Institute of Psychology and Allied Sciences, Amity University, Noida, Uttar Pradesh, India
[2]Professor, Amity Institute of Psychology and Allied Sciences, Amity University, Noida, Uttar Pradesh, India
*Corresponding Author

Received: May 06, 2025; Revision Received: May 18, 2025; Accepted: May 22, 2025

impair quality of life, increase the risk of suicide, and complicate treatment, as addressing one condition without tackling the other often leads to suboptimal outcomes.

The epidemiology of these disorders suggests a higher prevalence in populations exposed to chronic stress and limited access to mental health care. Law enforcement professionals, such as policemen, are particularly vulnerable due to the nature of their work. Their profession entails exposure to traumatic events, irregular schedules, high-pressure decision-making, and societal expectations of emotional stoicism (Violanti et al., 2018). Such occupational stressors elevate the risk of mental health conditions, with studies revealing that police officers experience higher rates of depression, anxiety, substance use, and suicide compared to the general population (Jetelina et al., 2020).

Stigma surrounding mental health in law enforcement compounds these challenges, often deterring individuals from seeking help. Policemen may perceive mental health struggles as a sign of weakness, jeopardizing their professional reputation and career advancement. This stigma not only delays intervention but also exacerbates the severity of symptoms, as untreated mental health conditions can spiral into crises.

This case study examines the experiences of Mr. AB, a 45-year-old policeman who self-referred for treatment of persistent low mood, excessive worry, and increased alcohol consumption. His struggles were precipitated by a job transfer that intensified financial stress and disrupted his usual coping mechanisms. The unique interplay of occupational stress, societal stigma, and personal vulnerabilities in Mr. AB's case underscores the importance of addressing MDD and AUD concurrently through tailored, evidence-based interventions. The following sections detail the comprehensive assessment, treatment, and outcomes of his therapeutic journey, offering insights into managing comorbid mental health conditions in high-stress professions.

REVIEW OF LITERATURE

The 2019 study by Sehran Khan Nisar, Muhammad Imran Rasheed, and Wang Qiang in the Journal of Affective Disorders explores the complex interplay between Major Depressive Disorder (MDD) and Alcohol Use Disorder (AUD), emphasizing the necessity of integrated treatment approaches. Through a longitudinal design, the study demonstrates that individuals with comorbid MDD and AUD face greater symptom severity, poorer social functioning, and increased difficulty in achieving recovery compared to those with singular diagnoses. Tailored interventions, including Cognitive Behavioral Therapy (CBT) and pharmacotherapy (e.g., SSRIs for depression and naltrexone for alcohol cravings), were shown to be most effective when applied concurrently, addressing both conditions in unison. The findings underline the value of the biopsychosocial model in understanding dual-diagnosis challenges and advocate for personalized, patient-centered therapeutic strategies to enhance outcomes. While comprehensive and methodologically robust, the study notes the importance of long-term follow-ups and diverse samples to further validate its conclusions and ensure broader applicability.

Theoretical Framework

Understanding Mr. AB's condition requires a multidimensional perspective that integrates biological, psychological, and social factors. This is best encapsulated by the **biopsychosocial model** proposed by Engel (1977), which highlights how interdependent systems influence health and illness. For Mr. AB, biological factors such as the neurochemical imbalances associated with Major Depressive Disorder (MDD) and the potential genetic predisposition to

Alcohol Use Disorder (AUD) interact with psychological stressors, such as maladaptive thought patterns, and social issues, including occupational stress and financial instability.

Cognitive Behavioral Theory (CBT) forms the foundation of the psychotherapeutic framework. Beck's (1976) theory emphasizes that distorted cognitions and behavioral patterns perpetuate psychological distress. For Mr. AB, cognitive distortions like catastrophizing and feelings of worthlessness drove his depressive symptoms, while avoidant behaviors, such as increased alcohol consumption, exacerbated his condition. CBT posits that identifying, challenging, and restructuring these maladaptive thoughts can foster emotional and behavioral change.

The application of the **Transtheoretical Model of Change (TTM)** (Prochaska & DiClemente, 1983) underpinned the use of Motivational Interviewing (MI). This model outlines stages of change—precontemplation, contemplation, preparation, action, and maintenance—through which individuals progress during behavioral transformation. Mr. AB's initial ambivalence about reducing alcohol consumption placed him in the contemplation stage. MI facilitated his progression by increasing his awareness of the discrepancies between his goals (e.g., being a better father) and his current behaviors (excessive alcohol use).

The Self-Medication Hypothesis (Khantzian, 1985) provides additional insight into Mr. AB's alcohol use. This theory suggests that individuals use substances like alcohol to cope with underlying psychological distress. In this case, Mr. AB's increased alcohol consumption can be seen as a maladaptive response to the stress of his job transfer, financial worries, and depressive symptoms. Understanding this dynamic allowed the treatment plan to address both the root causes of his distress and the maladaptive coping strategy itself.

From a sociocultural perspective, the **Social Cognitive Theory (SCT)** by Bandura (1986) emphasizes the interplay of personal, environmental, and behavioral factors in shaping actions. Mr. AB's occupational stress as a policeman, societal stigma surrounding mental health, and limited access to healthy coping mechanisms illustrate how environmental pressures influenced his mental health. SCT also highlights the importance of self-efficacy, or belief in one's ability to manage challenges, which was a central focus of his therapy. Finally, the **Diathesis-Stress Model** offers a lens for understanding how Mr. AB's vulnerabilities (e.g., low stress tolerance) were activated by external stressors (e.g., job transfer and financial insecurity), culminating in MDD and AUD. This framework underscores the need for interventions that reduce stress while building resilience and adaptive coping skills.

By synthesizing these theories, the treatment plan was designed to address the multifaceted nature of Mr. AB's struggles, targeting both the immediate symptoms and the underlying mechanisms contributing to his mental health challenges. This comprehensive theoretical grounding ensured that the interventions were both evidence-based and tailored to his unique needs.

Case Formulation

Mr. AB's difficulties can be understood through a biopsychosocial lens:

1. **Biological Factors:**
   - **Genetic Predisposition:** While Mr. AB reported no family history of mental illness, the familial occurrence of hypertension and diabetes indicates a potential vulnerability to stress-related conditions.
   - **Physiological Impact of Alcohol:** Chronic alcohol use likely exacerbated depressive symptoms, impairing neurotransmitter function and disrupting sleep patterns.
2. **Psychological Factors:**
   - **Cognitive Distortions:** Mr. AB exhibited patterns of catastrophizing ("I'll never regain financial stability") and personalization ("My family's struggles are entirely my fault"), which perpetuated feelings of worthlessness and guilt.
   - **Maladaptive Coping Mechanisms:** Alcohol became a primary coping strategy, masking emotional pain but reinforcing dependency.
3. **Social Factors:**
   - **Occupational Stress:** The transfer to a less favorable post removed supplementary income opportunities, increasing financial strain and diminishing his sense of control.
   - **Marital Strain:** Financial instability and alcohol use strained his relationship, reducing his emotional support system.
4. **Interpersonal Dynamics:**
   - Mr. AB's reluctance to seek help initially stemmed from cultural stigma around mental health and substance use, particularly within the police force. This formulation highlights the interplay between Mr. AB's stressors and maladaptive responses, reinforcing the need for a comprehensive, individualized treatment approach.

Mental Status Examination (MSE)

- **Appearance**: Disheveled, unkempt, indicative of low self-care.
- **Behavior**: Cooperative but restless, suggestive of internal agitation.
- **Speech**: Slow, soft-spoken, reflecting diminished energy and motivation.
- **Mood and Affect**: Depressed mood; affect congruent, marked by sadness and hopelessness.
- **Thought Content**: Preoccupied with financial worries and guilt; no suicidal ideation.
- **Cognition**: Alert and oriented but impaired concentration.
- **Insight and Judgment:** Recognizes problems but struggles with proactive change; judgment impaired by alcohol use.

Ethical Considerations

The treatment process adhered to ethical principles, ensuring respect for Mr. AB's autonomy and confidentiality. Informed consent was obtained for therapy and pharmacological interventions. Special care was taken to address the stigma he faced as a policeman, fostering a non-judgmental therapeutic environment. Given his role as a family provider, discussions included ethical considerations about managing disclosure and involving his family in psychoeducation without breaching his confidentiality.

Therapeutic Approach

The therapeutic approach for Mr. AB was comprehensive and dynamic, involving multiple strategies tailored to address his Major Depressive Disorder (MDD) and Alcohol Use Disorder (AUD). By leveraging the strengths of a multidisciplinary team, including the involvement of an intern therapist, the process was enriched with creative interventions, collaborative insights, and reflective feedback.

Step 1: Building Rapport and Initial Psychoeducation

The therapeutic journey began with establishing a strong rapport, an essential foundation for any successful intervention. Mr. AB was visibly hesitant in the initial sessions, often avoiding eye contact and minimizing his struggles.

Recognizing this, the primary therapist employed empathetic listening, ensuring that Mr. AB felt heard without fear of judgment. For instance, when Mr. AB expressed feelings of failure, the therapist responded, "It's not about failing; it's about facing challenges and finding ways to rise above them, and you've already taken a brave step by seeking help." Psychoeducation was then introduced to empower Mr. AB with knowledge about MDD and AUD. The sessions were interactive, using visual aids like flowcharts to explain the cyclical nature of depression and alcohol dependence. To keep the content relatable, the therapist incorporated examples from law enforcement scenarios, illustrating how unmanaged stress can escalate into mental health challenges.

The intern observed that Mr. AB seemed particularly receptive to analogies related to his profession, such as likening therapy to strategic planning during an investigation. The intern suggested incorporating role-play exercises where Mr. AB could simulate **"problem-solving"** his mental health issues, enhancing engagement.

Step 2: Addressing Alcohol Use Through Motivational Interviewing (MI)

Motivational Interviewing (MI) was central to addressing Mr. AB's ambivalence about reducing alcohol use. The sessions explored his conflicting feelings, balancing empathy with gentle challenges to his justifications for drinking. Key techniques included:

- **Reflective Listening:** When Mr. AB stated, "Drinking helps me forget my problems, even if just for a while," the therapist reflected, "It sounds like alcohol feels like a relief now, but I wonder if it's creating bigger problems later?"
- **Developing Discrepancy:** The therapist encouraged Mr. AB to contrast his values (e.g., being a dependable father) with his behaviors (e.g., drinking excessively). This discrepancy was highlighted through a values clarification worksheet, where Mr. AB listed his priorities and discussed how his actions aligned—or didn't—with those priorities.

Creative Approach: At the intern's suggestion, a visual "decision balance sheet" was used, where Mr. AB listed the pros and cons of drinking versus sobriety. This tangible exercise helped him visualize the long-term benefits of abstinence, reinforcing his motivation to change.

Resistance and Breakthroughs: Initially, Mr. AB resisted change, rationalizing his drinking as his "only escape." However, reflecting on a recent incident where his intoxication led to an argument with his wife became a pivotal moment. This incident was revisited multiple times in therapy, deepening his awareness of the negative impact of his alcohol use.

Step 3: Cognitive Behavioral Therapy (CBT) for Depression
Cognitive Behavioral Therapy (CBT) sessions focused on dismantling the distorted thought patterns fueling Mr. AB's depressive symptoms. The process was structured but adaptive, integrating creative techniques to sustain engagement.

- **Behavioral Activation:** Initially, Mr. AB struggled to identify activities that brought him joy. The therapist collaborated with him to create a weekly **"activity menu,"** including small tasks like taking his children to the park or preparing a meal with his wife. Progress was tracked, and Mr. AB was encouraged to reflect on how these activities affected his mood.
- **Cognitive Restructuring:** Negative automatic thoughts were addressed through a **"thought diary"** exercise. Mr. AB documented his thoughts, emotions, and behaviors in challenging situations, which were then discussed in therapy. For instance, his thought, "I'm a failure as a father," was reframed as, "I'm working hard to improve my situation, and every small step counts."

Intern's Observation and Suggestion: The intern noticed that Mr. AB enjoyed tangible, goal-oriented tasks. She suggested introducing a **"progress board"** where Mr. AB could visually track milestones, such as consecutive days of sobriety or successful completion of tasks. This approach was implemented and became a motivational tool. Creative Techniques:

- A **gratitude journal** was introduced to cultivate positive thinking. Mr. AB initially struggled to complete it but gradually found value in documenting small joys, like his children's laughter or his wife's support.
- **Visualization exercises** helped Mr. AB imagine positive scenarios, such as celebrating milestones with his family. These visualizations strengthened his belief in his ability to overcome challenges.

Step 4: Pharmacotherapy
Pharmacological interventions were integrated to stabilize Mr. AB's symptoms.

- **Sertraline (SSRI)** was prescribed to address his depressive symptoms, starting with a low dose and gradually titrating up to a therapeutic level. Regular follow-ups monitored side effects and assessed improvements in mood and concentration.
- **Naltrexone** was introduced to reduce alcohol cravings. Counseling sessions supplemented its use, focusing on managing potential triggers and reinforcing motivation for abstinence.

The intern played a crucial role in coordinating follow-ups, ensuring that Mr. AB adhered to his medication regimen and providing additional support during difficult weeks.

Step 5: Family Involvement
Family involvement was a key component of therapy, addressing the strain in Mr. AB's marital relationship and rebuilding trust. Joint sessions with his wife created a space for open communication, guided by the therapist.

- **Marital Counseling**: The sessions focused on resolving conflicts stemming from financial stress and alcohol use. Mr. AB's wife shared her feelings of frustration and helplessness, while Mr. AB expressed guilt and a desire to repair the relationship. These discussions were mediated to ensure mutual understanding and reduce blame.
- **Family Psychoeducation:** His wife received education about MDD and AUD, learning to recognize triggers for relapse and support Mr. AB without enabling his behaviors.

The therapist encouraged the couple to establish routines, like weekly family outings, to strengthen their bond. Creative Techniques:

- A "**communication log"** was introduced, where both partners documented positive interactions or efforts to resolve conflicts. Reviewing the log during sessions highlighted progress and reinforced collaborative problem-solving.

Intern's Observations and Suggestions

The intern provided valuable insights throughout the process. Observing Mr. AB's preference for structure, she suggested incorporating more visual tools, like the decision balance sheet and progress board, which became integral to therapy. She also noted that Mr. AB responded well to humor and lighthearted moments, prompting the therapist to integrate more casual, affirming interactions into sessions. Additionally, the intern recommended exploring group therapy with other law enforcement professionals to address occupational stress and reduce stigma. While this was deferred for logistical reasons, it remains a potential avenue for long-term support.

Outcome

Over the course of 12 weeks, Mr. AB exhibited notable improvements across multiple dimensions of his life, reflecting the effectiveness of the comprehensive therapeutic approach. The results were tracked through qualitative observations, self-reported progress, and standardized assessment tools, providing a multifaceted evaluation of his recovery.

1. **Improvements in Mental Health**
    - **Depressive Symptoms:** Mr. AB reported a significant reduction in core symptoms of Major Depressive Disorder (MDD). His sleep disturbances, which were marked by difficulty falling and staying asleep, improved to the point where he experienced uninterrupted rest for 6–7 hours per night. He described a "lighter" feeling in the mornings, a stark contrast to his previous sense of dread upon waking.
    - **Cognitive Functioning:** His concentration and focus improved considerably. Tasks that once felt overwhelming, such as completing routine paperwork at work, became manageable. These gains were supported by the use of sertraline and his active engagement in cognitive restructuring exercises during CBT.
    - **Emotional State:** Mr. AB described a renewed sense of hope and a reduced burden of guilt about his perceived failures as a provider. His mood was consistently stable, with fewer instances of irritability and sadness.

2. **Alcohol Use and Sobriety**
    - **Reduction in Alcohol Consumption:** Mr. AB successfully reduced his alcohol intake, with periods of complete abstinence spanning several days to weeks. By the end of the 12-week period, he reported consuming alcohol only occasionally and in controlled amounts, describing it as "no longer a crutch."
    - **Cravings and Relapse Prevention**: The use of naltrexone effectively suppressed cravings, which Mr. AB described as "manageable" rather than overwhelming. He credited the motivational techniques and self-reflection exercises for helping him resist triggers, such as social gatherings where alcohol was present.

- **Assessment Tools:**
  - **AUDIT (Alcohol Use Disorders Identification Test):** Mr. AB's initial AUDIT score was 24, indicating high-risk drinking and dependence. By the end of therapy, his score dropped to 8, placing him in the low-risk category.
  - **Timeline Followback (TLFB):** A weekly review of his drinking patterns revealed that his alcohol-free days increased from 1–2 per week at baseline to 5–6 per week by the conclusion of therapy.

3. **Occupational and Financial Stability**
   - **Work Attendance and Performance:** Mr. AB resumed attending work regularly, reporting greater focus and reduced absenteeism. He expressed pride in his ability to fulfill professional duties, describing himself as "more present" during tasks.
   - **Financial Management:** With the help of the therapist, Mr. AB adopted basic budgeting techniques, which alleviated his financial worries. He also explored opportunities for legitimate overtime work, reducing his dependence on bribes. These changes enhanced his sense of control over his financial situation, contributing to improved self-esteem.
4. **Family and Social Relationships**
   - **Improved Marital Relationship:** Joint sessions with his wife facilitated healthier communication and a stronger emotional bond. His wife reported feeling "more connected" to Mr. AB and appreciated his efforts to share responsibilities at home.
   - **Parenting and Family Time:** Mr. AB re-engaged with his children, spending quality time playing and helping with schoolwork. He described these interactions as a source of joy and motivation to maintain sobriety.
   - **Social Interactions:** While Mr. AB's social circle remained limited, he expressed a willingness to rebuild friendships, particularly with colleagues who had been supportive during his struggles.
5. **Results from Psychological Assessments**
   - **Beck Depression Inventory-II (BDI-II):** At baseline, Mr. AB's BDI-II score was 32, indicative of severe depression. By the end of therapy, his score dropped to 12, reflecting mild depression. This improvement aligned with his subjective reports of enhanced mood and motivation.
   - **Patient Health Questionnaire-9 (PHQ-9):** His PHQ-9 score decreased from 18 (moderate depression) at intake to 5 (minimal depression) by week 12.
   - **Cognitive Behavioral Therapy Progress Tracker:** Weekly evaluations of Mr. AB's engagement in behavioral activation and cognitive restructuring exercises showed steady improvement, with a 90% adherence rate to assigned tasks.

DISCUSSION

This case highlights the intricate interplay between Major Depressive Disorder (MDD) and Alcohol Use Disorder (AUD), emphasizing the critical need for integrated, concurrent treatment of these co-occurring conditions. Comorbid MDD and AUD are highly prevalent and significantly impair quality of life, making a multimodal treatment approach essential for sustainable recovery (Grant et al., 2015; Subramaniam et al., 2020).

Motivational Interviewing and Resistance Management

Motivational Interviewing (MI) proved to be a pivotal intervention in this case, particularly in addressing Mr. AB's ambivalence toward reducing alcohol consumption. Recent research

supports the efficacy of MI in reducing alcohol use and enhancing motivation for change in individuals with AUD. A meta-analysis by Lundahl et al. (2019) found that MI is associated with significant reductions in substance use, particularly when paired with other therapeutic modalities. In Mr. AB's case, MI not only reduced resistance but also facilitated self-reflection, allowing him to align his actions with his values as a father and husband.

Resistance encountered early in therapy underscores the importance of a patient-centered approach. Instead of imposing rapid behavioral changes, the therapist allowed Mr. AB to progress at his own pace, fostering intrinsic motivation. This strategy aligns with findings by Miller and Rollnick (2021), which advocate for collaborative, empathetic engagement to enhance treatment adherence.

Cognitive Behavioral Therapy (CBT) and Depressive Symptoms

CBT provided Mr. AB with the cognitive and behavioral tools to manage his depressive symptoms effectively. Behavioral activation helped reintroduce pleasure and achievement into his daily routine, while cognitive restructuring allowed him to challenge and replace distorted thoughts that perpetuated his low mood. A study by Cuijpers et al. (2020) highlights CBT as one of the most effective psychotherapeutic approaches for MDD, demonstrating sustained improvements in mood and functioning. The introduction of creative techniques, such as the gratitude journal and visualization exercises, added depth to the therapeutic process. These approaches were instrumental in fostering resilience and self-efficacy. Emerging evidence supports the use of such techniques in enhancing cognitive and emotional outcomes. For example, a randomized controlled trial by Carcioppolo et al. (2022) demonstrated that gratitude journaling significantly reduces depressive symptoms by shifting attention toward positive experiences and reinforcing adaptive thought patterns.

Pharmacotherapy and Craving Management

The integration of pharmacotherapy in this case was essential for stabilizing mood and reducing alcohol cravings. Sertraline, an SSRI, effectively targeted Mr. AB's depressive symptoms, consistent with findings by Shelton et al. (2020), which affirm the efficacy of SSRIs in alleviating MDD. Additionally, naltrexone played a crucial role in curbing alcohol cravings, a finding corroborated by Jonas et al. (2021), who identified naltrexone as a frontline pharmacological option for AUD with high success rates in achieving abstinence.

The combination of pharmacotherapy and psychotherapy highlights the importance of a multidisciplinary approach. A study by Watkins et al. (2018) underscores the synergistic effects of combining SSRIs and psychosocial interventions, demonstrating superior outcomes compared to monotherapies.

Family Involvement and Social Support

Family involvement emerged as a cornerstone of Mr. AB's recovery. Joint sessions with his wife facilitated open communication and helped rebuild trust, addressing the relational strain exacerbated by his alcohol use. Recent studies emphasize the role of family dynamics in recovery from comorbid conditions. For instance, McCrady and Epstein (2018) found that involving family members in treatment significantly improves outcomes in individuals with AUD, particularly by enhancing adherence and reducing relapse risk.

Mr. AB's improved relationship with his wife and children not only contributed to his emotional well-being but also reinforced his motivation to maintain sobriety. This aligns with findings by Kelly et al. (2019), who demonstrated that strong familial support networks are predictive of long-term recovery in individuals with dual diagnoses.

Broader Implications

This case also sheds light on the unique challenges faced by individuals in high-stress professions, such as law enforcement. Occupational stressors, stigma surrounding mental health, and the normalization of maladaptive coping mechanisms like alcohol use create barriers to seeking help. A study by Jetelina et al. (2020) revealed that police officers are at an elevated risk of both MDD and AUD, highlighting the urgent need for targeted mental health interventions in this population. The success of this intervention underscores the importance of tailoring therapeutic approaches to individual needs, integrating evidence-based practices with creative and patient-specific strategies. Moreover, it highlights the value of involving trainees, such as interns, whose observations and suggestions can enrich the therapeutic process.

CONCLUSION

This case study underscores the importance of a multifaceted, patient-centered approach in treating co-occurring MDD and AUD. By combining MI, CBT, pharmacotherapy, and family involvement, the intervention not only alleviated symptoms but also empowered Mr. AB with tools for sustained recovery. Future research should explore the long-term efficacy of such integrated approaches, particularly in high-risk populations like law enforcement professionals.

REFERENCES

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: *American Psychiatric Publishing.*

Bandura, A. (1986). Social foundations of thought and action: A social cognitive theory. Prentice-Hall.

Beck, A. T. (1976). Cognitive therapy and the emotional disorders. *International* Universities Press.

Carcioppolo, N., Denes, A., & Myers, L. (2022). The impact of gratitude journaling on depressive symptoms: A randomized controlled trial. Journal of Positive Psychology, 17(1), 33–45. https://doi.org/10.1080/17439760.2021.1974038

Cuijpers, P., Karyotaki, E., Weitz, E., Andersson, G., Hollon, S. D., & van Straten, A. (2020). The effects of psychotherapies for major depression in adults on remission, recovery and improvement: A meta-analysis. *Journal of Affective Disorders*, 267, 39–49. https://doi.org/10.1016/j.jad.2020.02.002

Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. Science, *196*(4286), 129–136. https://doi.org/10.1126/science.847460

Grant, B. F., Goldstein, R. B., Saha, T. D., Chou, S. P., Jung, J., Zhang, H., Pickering, R. P., Ruan, W. J., Smith, S. M., Huang, B., & Hasin, D. S. (2015). Epidemiology of DSM-5 alcohol use disorder: Results from the National Epidemiologic Survey on Alcohol and Related Conditions III. *JAMA Psychiatry, 72*(8), 757–766. https://doi.org/10.1001/jamapsychiatry.2015.0584

Jetelina, K. K., Molsberry, R. J., Gonzalez, J. R., Beauchamp, A. M., & Hall, T. (2020). Prevalence of mental illness and associated factors among law enforcement officers. *JAMA Network Open, 3*(4), e204060. https://pubmed.ncbi.nlm.nih.gov/33026452/

Jonas, D. E., Amick, H. R., Feltner, C., Bobashev, G., Thomas, K., Wines, R., & Garbutt, J. C. (2021). Pharmacotherapy for adults with alcohol use disorders in outpatient settings: A systematic review and meta-analysis. *JAMA, 325*(2), 222–235. https://doi.org/10.1001/jama.2020.25062

Kelly, J. F., Hoeppner, B., Stout, R. L., & Pagano, M. E. (2019). Determining the relative importance of the mechanisms of behavioral change within Alcoholics Anonymous:

A multiple mediator analysis. Addiction, *114*(8), 1536–1547. https://doi.org/10.1111/add.14679

Kessler, R. C., Nelson, C. B., McGonagle, K. A., & Edlund, M. J. (2003). The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilization. *American Journal of Orthopsychiatry, 73*(1), 5–31. https://doi.org/10.1037/0002-9432.73.1.5

Khantzian, E. J. (1985). The self-medication hypothesis of addictive disorders: Focus on heroin and cocaine dependence. *American Journal of Psychiatry, 142*(11), 1259–1264. https://doi.org/10.1176/ajp.142.11.1259

Lundahl, B., Kunz, C., Brownell, C., Tollefson, D., & Burke, B. L. (2019). Meta-analysis of motivational interviewing: Twenty-five years of empirical studies. *Research on Social Work Practice, 29*(2), 223–235. https://doi.org/10.1177/1049731518766510

McCrady, B. S., & Epstein, E. E. (2018). Family and couple treatment for alcohol and drug use disorders: Is it effective? Current Opinion in Psychology, 21, 45–49. https://doi.org/10.1016/j.copsyc.2017.09.005

Miller, W. R., & Rollnick, S. (2021). Motivational interviewing: Helping people change (4th ed.). Guilford Press.

Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology*, *51*(3), 390–395. https://doi.org/10.1037/0022-006X.51.3.390

Shelton, R. C., Claassen, C. A., & Delgado, P. L. (2020). SSRIs for major depressive disorder: Efficacy and tolerability in light of new evidence. *Journal of Clinical Psychiatry, 81*(5), 128–134. https://doi.org/10.4088/JCP.20com13549

Subramaniam, M., Abdin, E., Vaingankar, J. A., & Chong, S. A. (2020). Comorbid alcohol use disorders and depression: A population-based epidemiological study. Journal of Addiction Medicine, *14*(2), 146–154. https://doi.org/10.1097/ADM.0000000000000584

Violanti, J. M., Owens, S. L., McCanlies, E., Fekedulegn, D., Andrew, M. E., & Hartley, T. A. (2018). Law enforcement work and alcohol use: A systematic review. Policing: An *International Journal*, 41(5), 683–694. https://doi.org/10.1108/PIJPSM-05-2017-0061

Watkins, K. E., Ober, A. J., Lamp, K., Lind, M., Setodji, C. M., & Hunter, S. B. (2018). Collaborative care for opioid and alcohol use disorders in primary care: The SUMMIT randomized clinical trial. *JAMA Internal Medicine, 178*(6), 829–837. https://doi.org/10.1001/jamainternmed.2018.0700

World Health Organization. (2023). Depression. World Health Organization. Retrieved from https://www.who.int/news-room/fact-sheets/detail/depression

Zuckerman, M. (1999). Vulnerability to psychopathology: A biosocial model. American Psychological Association. https://doi.org/10.1037/10316-000

Acknowledgment

The author(s) appreciates all those who participated in the study and helped to facilitate the research process.

Conflict of Interest

The author(s) declared no conflict of interest.

How to cite this article: Gupta, K. & Sharma, R. (2025). Navigating Dual Challenges: Treating Depression and Alcohol Use Disorder in a Policeman. *International Journal of Indian Psychology, 13*(2), 1848-1858. DIP:18.01.171.20251302, DOI:10.25215/1302.171