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Posttraumatic stress disorder and alcohol dependence: Individual and combined associations with social network problems☆

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ABSTRACT

People with either posttraumatic stress disorder (PTSD) or alcohol dependence (AD) are apt to report problems in their social networks, including low perceived support and elevated conflict. However, little research has examined social networks among people with comorbid PTSD/AD despite evidence suggesting these two conditions commonly co-occur and are linked to particularly severe problems. To test the hypothesis that people with comorbid PTSD/AD experience particularly elevated social network problems, individuals with lifetime diagnoses of PTSD, AD, comorbid PTSD/AD, or no lifetime history of Axis I psychopathology in the National Comorbidity Survey-Replication were compared on four dimensions of social networks: (1) Closeness, (2) Conflict, (3) Family Support, and (4) Apprehension. Persons with PTSD, AD, or comorbid PTSD/AD endorsed more problems with the Conflict, Family Support, and Apprehension factors compared to people with no history of Axis I psychopathology. Moreover, individuals with comorbid PTSD/AD endorsed greater Apprehension and significantly less Family Support compared to the other three groups. Results suggest people with comorbid PTSD/AD experience increased problems with their family as well as greater concerns about enlisting social support than even people with PTSD or AD alone. Treatments for people suffering from comorbid PTSD/AD should consider assessing for and possibly targeting family support and apprehension about being close to others.

1. Introduction

Posttraumatic stress disorder (PTSD) and alcohol dependence (AD) are chronic, often disabling conditions (Hasin, Stinson, Ogburn, & Grant, 2007; Kessler, 2000; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Samokhvalov, Popova, Room, Ramos, & Rehm, 2010). Moreover, PTSD and AD are commonly comorbid (Back, Jackson, Sonne, & Brady, 2005; Brown, Recupero, & Stout, 1995; Kessler et al., 1997; Pietrzak, Goldstein, Southwick, & Grant, 2011; Stewart, 1996). Research suggests that compared to the presence of unimorbid PTSD or AD, comorbid PTSD/AD is associated with greater problem severity across multiple indices. For example, the co-occurrence of these two disorders is associated with a more severe clinical presentation (Mills, Teeson, Ross, & Peters, 2006; Ouimette, Goodwin, & Brown, 2006), including increased co-occurrence of additional anxiety disorders and depression (Bonin, Norton, Asmundson, Dicurzio, & Pidlubney, 2000; Drapkin et al., 2012; Rash, Coffey, Baschnagel, Drobes, & Saladin, 2008; Read, Brown, & Kahler, 2004), a longer history of problematic substance use, a greater likelihood of suicide attempts (Bonin et al., 2000), and worse treatment outcomes (e.g., Brown & Wolfe, 1994; Najavits, Weiss, & Shaw, 1999; Ouimette, Brown, & Najavits, 1998; Ouimette, Finney, & Moos, 1999). As such, it is important to identify factors that differ between people with comorbid PTSD/AD and those suffering from only one of these problems in order to advance our currently limited understanding of what may account for the particularly severe problems introduced by this comorbidity.

People with PTSD experience elevated problems with social networks. There is a strong negative association between social support and symptoms of posttraumatic stress subsequent to

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traumatic event exposure (Brewin, Andrews, & Valentine, 2000; Danner & Radnitz, 2000; Eriksson, Vande Kemp, Gorsuch, Hoke, & Foy, 2001; Kaniasty & Norris, 2008; Tucker, Pfefferbaum, Nixon, & Dickson, 2000). Research has consistently demonstrated a bi-directional association between PTSD severity and social support (Kaniasty & Norris, 2008; Turner, 1981). For example, one study found that pre-trauma social support predicted PTSD symptoms 6–12-months following traumatic event exposure, while both pathways from social support to PTSD, as well as PTSD to social support were significant 12–18 months following the traumatic event (Kaniasty & Norris, 2008). Symptoms of PTSD, such as loss of interest in activities, feelings of estrangement of others, and increased anger are possible mechanisms underlying decreases in social support following a traumatic event (Kaniasty & Norris, 2008). People with PTSD also endorse elevated levels of social conflict (Galovski & Lyons, 2004; Monson, Taft, & Fredman, 2009; Monson et al., 2012). Indeed, PTSD has been associated with relatively elevated levels of both physical and psychological aggression in significant interpersonal relationships (Taft, Watkins, Stafford, Street, & Monson, 2011). For example, in a sample of treatment seeking male veterans with a partner, approximately 33% endorsed perpetrating physical aggression, and 91% endorsed perpetrating psychological aggression toward their partner (Taft, Weatherill et al., 2009). Similarly, PTSD symptoms were positively correlated with both physical and psychological victimization and perpetration in a civilian sample of flood survivors (Taft, Monson et al., 2009).

Deficits in social support have also been linked to alcohol use. Research suggests people with supportive friends and families report more success in reducing alcohol use (Beattie & Longabaugh, 1997; Gordon & Zrull, 1991; Tucker, Vuchicich, & Pukish, 1995). Social support for alcohol-related treatment and abstinence, more specifically, is positively associated with percentage of days abstinent following treatment, and negatively correlated with the proportion of days of heavy drinking following treatment (Beattie & Longabaugh, 1999). Research on alcohol use disorders and relationship functioning has suggested an association between alcohol use and relationship difficulties, including lower marital satisfaction (Marshal, 2003) and elevated marital aggression (Leonard & Blane, 1992; Murphy & O'Farrell, 1994). Similarly, effects of drinking in men with an alcohol use disorder have been linked to elevated social conflict (Kachadourian, Taft, O'Farrell, Doron-LaMarca, & Murphy, 2012; O'Farrell & Murphy, 1995). In fact, social conflict has been associated with the maintenance of alcohol use via its correlation with relapse during alcohol use quit attempts (Marlatt & Gordon, 1980). Despite a corpus of data suggesting problems with social networks are linked to both PTSD and AD, relatively little research has examined social network problems among people with comorbid PTSD/AD.

Preliminary evidence suggests that people with PTSD/AD may experience particularly severe problems with social networks. People with comorbid PTSD/AD are less likely to be married (Drapkin et al., 2012) and more likely to report interpersonal problems (Najavits et al., 1998). Given these data, the current study tested if the combination of PTSD and AD is related to particularly elevated social network problems, even relative to each of these conditions alone. First, we predicted that people with either lifetime PTSD, AD, or comorbid PTSD/AD would report lower levels of perceived social closeness to others, decreased ability to rely on or open up to relatives, greater social conflict, and more apprehension about utilizing social support when compared to those without a lifetime history of Axis I psychopathology. Second, it was predicted that individuals with lifetime comorbid PTSD/AD would report lower perceived social support in the form of lower perceived closeness in general, as well as reduced perceived ability to rely on or open up to relatives, greater perceived social conflict, and more apprehension about social support when compared to people who meet lifetime criteria for only one of these disorders.

After first examining the predicted associations between PTSD and AD with these social network factors, these associations were examined after statistically covarying for variance accounted for by other comorbid conditions. Given both PTSD and AD are commonly comorbid with multiple types of psychopathology that also may impact social networks (e.g., major depressive disorder, panic disorder; Back, Jackson, Sonne, & Brady, 2005; Bonin, Norton, Asmundson, Dicurzio, & Pidlubney, 2000; Drapkin et al., 2012; Jacobsen, Southwick, & Kosten, 2001; Rash, Coffey, Baschnagel, Drobes, & Saladin, 2008; Stewart, 1996), it is important to try and gauge the degree to which comorbid PTSD/AD is uniquely related to social network problems above and beyond other comorbid conditions. While analysis of covariance does not equate groups given important group differences (Miller & Chapman, 2001), it can be used to tentatively gauge the uniqueness of an association given inferences are situated within the limitations of the approach (Zinbarg, Suzuki, Uliaszek, & Lewis, 2010).

2. Method

2.1. Participants

The current study examined data from the National Comorbidity Survey-Replication (NCS-R; Kessler & Merikangas, 2004). This nationwide epidemiological study included a nationally-representative sample of English-speaking adults (≥17 years old) from 48 states in the United States. To identify potential participants, a stratified, multistage probability sample was utilized. Participation in Part I was adjusted for the differential probability of selection between the sample and the United States population with regard to sociodemographic and geographic variables.

The NCS-R procedure employed a structured research interview (Kessler et al., 2004) to evaluate psychiatric disorders as categorized in the *Diagnostic and Statistical Manual–Fourth Edition* (DSM-IV; American Psychiatric Association [APA], 1994). Interviews were administered by researchers in participants' homes between February 2001 and April 2003. There was a 73% response rate for the interview. See Kessler et al. (2004) for a detailed description of sampling procedures and methods.

The structured interview consisted of two parts. Part I was comprised of a core diagnostic interview that was administered to all participants ($n = 9282$). More specifically, the World Health Organization's Composite International Diagnostic Interview (CIDI; Kessler et al., 2004) was employed to index psychopathology diagnoses. Part I was completed in approximately one hour. Part II was then administered to a subsample of participants ($n = 5692$). Part II more explicitly focused on specific types of psychopathology (e.g., PTSD), as well as correlates and risk factors for psychopathology (e.g., social support measures). Participation in Part II of the study was determined based on the presence of at least one of the following criteria: (1) lifetime diagnosis of any disorder in Part I, (2) meeting subthreshold criteria for a DSM-IV-defined Axis I disorder, (3) ever having sought treatment for a psychological disorder, (4) use of psychotropic medications in the past 12-months, or (5) lifetime history of attempted suicide or a plan to commit suicide. A total of 59% of individuals meeting at least one of these criteria participated in Part II. Finally, in addition to individuals selected for Part II based on these criteria, a probability subsample of other respondents was also included in Part II; thus, an additional 25% of the entire sample was also selected to participate in Part II (Kessler et al., 2004).

All portions of the interview were administered by professionally trained interviewers who were closely supervised by the