



Comorbidity of posttraumatic stress disorder with alcohol dependence among US adults: Results from National Epidemiological Survey on Alcohol and Related Conditions



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ABSTRACT

Background: Despite the high rates of comorbidity of post-traumatic stress disorder (PTSD) and alcohol dependence (AD) in clinical and epidemiological samples, little is known about the prevalence, clinical presentation, course, risk factors and patterns of treatment-seeking of co-occurring PTSD-AD among the general population.

Methods: The sample included respondents of the Wave 2 of the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC). Weighted means, frequencies and odds ratios (ORs) of sociodemographic correlates, prevalence of psychiatric disorders and rates of treatment-seeking were computed.

Results: In the general population, the lifetime prevalence of PTSD only, AD only and PTSD-AD was 4.83%, 13.66% and 1.59%, respectively. Individuals with comorbid PTSD-AD were more likely than those with PTSD or AD only to have suffered childhood adversities and had higher rates of Axis I and II disorders and suicide attempts. They also met more PTSD diagnostic criteria, had earlier onset of PTSD and were more likely to use drugs and alcohol to relieve their PTSD symptoms than those with PTSD only; they also met more AD diagnostic criteria than those with AD only and had greater disability. Individuals with PTSD-AD had higher rates of treatment seeking for AD than those with AD only, but similar rates than those with PTSD only.

Conclusion: PTSD-AD is associated with high levels of severity across a broad range of domains even compared with individuals with PTSD or AD only, yet treatment-seeking rates are very low. There is a need to improve treatment access and outcomes for individuals with PTSD-AD.

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1. Introduction

Posttraumatic stress disorder (PTSD) is characterized by symptoms of re-experiencing, avoidance and increased arousal following exposure to a traumatic event (American Psychiatric Association, 1994). Epidemiological studies indicate that PTSD has a 12-month prevalence of 1.33–3.5% (Creamer et al., 2001; Kessler et al., 2005) and a lifetime prevalence of 6.6–7.8% (Breslau et al., 1991, 1998; Kessler et al., 1995; Pietrzak et al., 2011; Resnick et al., 1993). It is often comorbid with other psychiatric disorders (Creamer et al., 2001; Pietrzak et al., 2011), and associated with substantial

personal, economic and other societal costs (Kessler, 2000; Kessler et al., 2005).

Prior clinical (Behar, 1987; Kofoed et al., 1993; Saladin et al., 1995; Riggs et al., 2003; Evren et al., 2011) and epidemiological studies (Chilcoat and Menard, 2003; Grant et al., 2008; Kessler et al., 1997a,b) have consistently documented a strong association between PTSD and alcohol use disorders. Clinical studies have found that among individuals with PTSD, heavy alcohol drinking is associated with greater number (Behar, 1987) and more severe PTSD symptoms (Saladin et al., 1995), and prolonged course of illness (Herman, 1992; Yehuda et al., 1995). In addition, individuals with comorbid PTSD and alcohol dependence (AD) have higher prevalence of childhood trauma (Evren et al., 2011), earlier onset of AD symptoms (Driessen et al., 2008), poorer socioeconomic status (Riggs et al., 2003), and poorer physical and mental health (Evren et al., 2011), compared with those with AD only and their increased alcohol use is positively correlated with PTSD symptom severity (Bremner et al., 1996). Recent studies in clinical samples

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have suggested a reciprocal relationship between alcohol use and PTSD symptom improvement (Back et al., 2006), and trauma-focused exposure therapy significantly improved the symptoms of AD (Coffey et al., 2006).

While previous studies have provided substantial valuable information concerning the comorbidity of PTSD and AD, conclusions from clinical studies cannot be generalized to community populations. Knowledge of the clinical presentation, course, and risk factors of comorbidity of PTSD-AD among general population is important for understanding etiologic connections and to develop more effective prevention and treatment interventions. To fill this gap, we sought to build on previous work by employing a bidirectional approach to examine the comorbidity of AD and PTSD, utilizing the 2004–2005 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC). This approach provides a unique opportunity to investigate the incremental effect of having both disorders relative to either alone in regard to strength of associations with particular sociodemographic features and with other DSM-IV disorders. Specifically, we sought to: (1) provide prevalence estimates of comorbid lifetime PTSD and AD (PTSD-AD) among sociodemographic subgroups; (2) examine potential childhood and family environmental risk factors for PTSD-AD; (3) characterize the clinical presentation, course, psychosocial functioning, and comorbidity pattern of PTSD-AD; (4) Investigate the treatment seeking patterns among individuals with PTSD-AD.

2. Method

2.1. Sample

The 2004–2005 Wave 2 sample of the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) was used in the present study. The NESARC is based on a nationally representative sample of the US non-institutionalized population 18 years of age or older who reside in households and group quarters (e.g., college dormitories, group homes, boarding homes) throughout the 50 states and the District of Columbia. A detailed description of the NESARC Wave 1 and 2 methodologies is reported elsewhere (Grant et al., 2003; Grant and Kaplan, 2007; Read et al., 2004). African Americans, Hispanics, and adults aged 18–24 were over-sampled, with data adjusted for over-sampling and household- and person-level non-response. All procedures, including informed consent, received full ethical review and approval from the US Census Bureau and US Office of Management and Budget.

The Wave 1 NESARC surveyed 43,093 respondents, yielding a response rate of 81% (Grant et al., 2003). Participants in Wave 1 were contacted to be re-interviewed in Wave 2. Excluding ineligible respondents, (e.g., deceased), the response rate for Wave 2 was 86.7%, resulting in 34,653 respondents (Grant et al., 2008). Sample weights are described elsewhere (Grant and Kaplan, 2007) and were developed to adjust for Wave 2 non-response, socio-demographic factors, and the presence of any psychiatric diagnoses in Wave 1. Weighted data were adjusted to be representative of the US civilian population based on estimates from the 2000 census.

In our study, participants who meet a diagnosis of lifetime PTSD (without AD; $n=2463$), lifetime AD (without PTSD; $n=4914$) or both were included. Those who meet both lifetime PTSD and lifetime AD compose the PTSD-AD comorbidity group ($n=597$).

2.2. Measures

2.2.1. Socio-demographic measures. Sociodemographic measures included sex, age, race-ethnicity, nativity, educational level, marital status, place of residence, region of the country, individual income and type of health insurance.

2.2.2. Childhood adversities. Previous studies have suggested childhood adversities and negative family environment as risk factors for AD and PTSD (Bromet et al., 1998; Brewin et al., 2000; Ozer et al., 2003). To investigate their role in the course of comorbidity of PTSD-AD, this study also incorporated these measures. Childhood adversities include verbal abuse, physical abuse, sexual abuse, and neglect. Respondents completed a series of questions regarding exposure to childhood abuses occurring before age 18. Response categories for most scale items were 1 = never, 2 = almost never, 3 = sometimes, 4 = fairly often, and 5 = very often. Response category values were summed across items to produce scales. Verbal and physical abuse was assessed using questions from the Conflict Tactics Scale (Straus, 1979). Verbal abuse items assessed how often caregivers insulted, swore at, said hurtful things, threatened respondents with violence or acted in any other way that made respondents afraid that they would be physically hurt or injured. Physical abuse items ascertained the frequency of caregiver violent behavior toward the

respondent such as pushing, grabbing, shoving, slapping or hitting so hard that resulted in marks or injuries. Emotional and physical neglect were assessed using questions from the Childhood Trauma Questionnaire (Bernstein et al., 1994). To assess physical neglect, respondents were queried how often they were made to do chores too difficult or dangerous for someone their age, were left unsupervised when they were too young to be alone, were not provided with regular meals or adequate clothing, or did not receive necessary medical treatment. Emotional neglect was assessed with three items querying whether there was someone in the respondent's family who wanted him or her to be success, help him or her to feel important or was a source of strength and support. The CTQ also includes an endangerment item that assesses whether respondents were made to do chores that were dangerous for someone their age. Previously validated questions (Wyatt, 1985) regarding sexual experiences that were unwanted, involved an adult, or occurred when the respondent was too young to know what was happening were used to assess sexual abuse. These questions queried about touching and fondling, touching in a sexual way and attempting or actually having sexual intercourse.

Negative family environment measures include vulnerable family environment operationalized, as in prior studies, as parental absence or separation from a biological parent before age 18 (Alegria et al., 2010; Vesga-López et al., 2008), parental divorce, parental history of alcohol and drug use problems, parental behavioral problem, and partner with alcohol problem.

2.2.3. DSM-IV diagnostic interview. All psychiatric diagnoses, except for psychotic disorder, were made according to DSM-IV criteria (American Psychiatric Association, 1994) through the NIAAA Alcohol Use Disorder and Associated Disabilities Interview Schedule-DSM-IV Version (AUDADIS-IV), a reliable and valid diagnostic interview designed to be used by nonprofessional interviewers (Grant et al., 2001). Axis I diagnoses investigated in the survey comprised three main groups: (1) substance use disorders (including alcohol abuse and dependence, drug abuse and dependence, and nicotine dependence); (2) mood disorders (including major depressive disorder, dysthymia, and bipolar disorder); and (3) anxiety disorders (including panic disorder, social anxiety disorder, specific phobia, and generalized anxiety disorder). History of ADHD and conduct disorder and personality disorders were assessed on a lifetime basis. The test-retest reliability of AUDADIS-IV has been reported elsewhere and range from good to excellent (Grant et al., 2003; Stinson et al., 2008).

2.2.4. Lifetime alcohol dependence disorder. Consistent with DSM-IV, lifetime diagnoses of alcohol dependence diagnoses required 3 or more of the 7 DSM-IV dependence criteria in the last 12 months or during any previous 12-month period (Hasin et al., 2007). The reliability of the AUDADIS-IV alcohol diagnoses is documented in clinical and general population samples (Chatterji et al., 1997; Grant et al., 2003, 1995; Hasin et al., 1997a,b), with test-retest reliability ranging from good to excellent ($=0.70-0.84$). Convergent, discriminant, and construct validity of AUDADIS-IV alcohol use disorder criteria and diagnoses were good to excellent (Hasin et al., 1990; Hasin and Paykin, 1999; Hasin et al., 2003, 1997a,b).

2.2.5. Lifetime post-traumatic stress disorder and history of traumatic experiences. Past year and prior-to-past year diagnoses of PTSD were assessed in the Wave 2 NESARC. PTSD symptoms were assessed among individuals exposed to traumatic events in which both of the following had been present: (1) the person experienced, witnessed or was confronted with an event(s) that involved actual or threatened death or serious injury to the physical integrity of self or others; and (2) the person's response involved intense fear. DSM-IV criteria for PTSD were assessed for the individual's, self-reported, worst traumatic event. PTSD was diagnosed when all of the following criteria were present, for at least a month, following exposure to the worst traumatic event: (1) persistent re-experience of the event; (2) persistent avoidance of stimuli associated with trauma and numbing of general responsiveness (as indicated by three or more DSM-IV symptoms); and (3) persistent symptoms of increased arousal (as indicated by two or more DSM-IV PTSD symptoms). PTSD diagnoses required three or more of the seven DSM-IV dependence criteria in lifetime period. The NESARC asked 23 questions, one or two for each type of traumatic experience. Twenty-two questions were about events that qualify as traumatic events in DSM-IV, and the last question inquired about "any other extremely stressful or traumatic experience." Questions about having experienced/witnessed a terrorist attack included one question for "any terrorist attack" and an additional question addressing the 9/11 terrorist attacks. Finally, the NESARC allowed for examination of other types of traumatic events experienced during a war, revolutionary or armed conflict, as a military combat, relief worker, unarmed civilian or refugee. Test-retest reliability coefficients for lifetime and 12-month PTSD diagnoses were fair to good ($\kappa=0.64$ and 0.77 , respectively; Ruan et al., 2008).

2.2.6. Course and disability. Variables including age of onset, number of diagnostic criteria met, and duration of the longest episode were examined to compare the course of AD, PTSD and PTSD-AD. Moreover, individuals with PTSD were asked if they ever used any substance, including alcohol or drugs to relieve their PTSD symptoms. Previous clinical studies had also suggested that trauma may predispose victims to developing additional disorders through increased impulsivity (Roy, 2005; Zlotnick et al., 1997) and emotion dysregulation (van der Kolk and Fisler, 1994). To test this hypothesis in a community sample, we measured the impulsivity by asking

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