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Discrepancies between clinical needs and helpseeking behaviors in co-occurring posttraumatic stress and alcohol use disorders

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Abstract

Objective: The aim of the study was to compare subjects dually diagnosed with posttraumatic stress disorder (PTSD) and alcohol use disorder (AUD) to those with only one or none of these conditions regarding helpseeking needs and behaviors.
Method: Data from a large community sample (N = 3694) were used to assess the associations among lifetime PTSD and AUD, other psychiatric disorders, clinical characteristics and lifetime helpseeking behaviors derived from a semi-structured interview.
Results: Comorbid individuals had more severe clinical profiles and were more impaired than individuals with either PTSD or AUD alone or those with no/other psychiatric conditions. However, they did not differ in overall helpseeking behavior from any other group. Those with comorbid PTSD/AUD were even less likely than the other groups to seek help for depression and anxiety disorders through specific treatment facilities or the use of prescribed psychotropic drugs.
Conclusions: Despite a greater need for treatment the comorbid group did not seek more help than the others. Their lower use of prescribed drugs supports the self-medication hypothesis, suggesting that those individuals relieve their symptoms through higher alcohol use instead. Our findings underline the need for health care facilities to encourage helpseeking behavior in the aftermath of stressful life events.
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1. Introduction

The clinical presentation of posttraumatic stress disorder (PTSD) is frequently affected by a considerable amount of comorbid conditions, such as mood and anxiety disorders as well as increased suicidality [1,2]. Moreover, previous research has suggested that the course and clinical profile of PTSD might be especially complicated by the presence of comorbid alcohol use disorders (AUD) [3]. Indeed, those with dually diagnosed PTSD/AUD tend to have more comorbid conditions, greater impairment [4] and therefore poorer treatment outcomes than those with only one of the two conditions [5]. It is assumed that both conditions are functionally related whereof each of them contributes to the maintenance of the other one [6]. Conceptual models, such as the self-medication model, suggest that an increased use of alcohol may be seen as an attempt to cope with severe traumatic experiences [7–9]. Actually, the co-occurrence of PTSD and AUD is more prevalent among individuals with more severe traumatization, such as the experience of sexual abuse in childhood, in both clinical [10,11] and epidemiological samples [2,12].

In sum, due to a greater need for help one might expect that those with both conditions seek psychiatric help more frequently than those with one condition only [13,14]. In fact, in a helpseeking population, an overall higher service use was found in those with comorbid PTSD/AUD compared to those with PTSD alone [15] while other studies found AUD as a comorbid condition in general to decrease the likelihood of service use for anxiety disorders [16] and depression [17]. Unfortunately, most studies on this topic have relied on clinical samples, which hinder a naturalistic

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view of how an interplay of these two conditions might affect helpseeking behavior. To our knowledge there is only one study to date that investigated helpseeking behavior in individuals with comorbid PTSD and AUD from an epidemiological perspective [4]. Although their findings suggested greater clinical severity in individuals with comorbid PTSD/AUD than in those with PTSD alone, these groups did not differ in their helpseeking behavior [4]. However, the generalization of these results is limited since the authors did not adjust for other important factors that might affect or promote helpseeking behavior. Indeed, according to the behavioral model of mental health service use [18], the role of predisposing characteristics related to service use, such as individual rather than illness-related tendencies (e.g. age or gender), as well as enabling factors, that enable a person to make use of mental health services (e.g. socio-economic status, health insurance), should be determined. This, to our knowledge, has not been examined in individuals with comorbid PTSD/AUD so far.

On the one hand, it can be assumed that the comorbid condition of PTSD and AUD is associated with a more severe clinical representation of illness, which suggests a greater need for help. On the other hand, it has been suggested that the comorbid condition of AUD in individuals with PTSD might arise from an attempt to self-medicate their symptoms, which, in turn, might supersede their individual need for treatment. The purpose of the current study was to compare the objectively assessed need for treatment in terms of clinical characteristics as well as indicators of past helpseeking behavior among individuals with comorbid PTSD/AUD and those with either PTSD or AUD alone, in a large community sample. More precisely, we aimed to describe the comorbidity and other clinical correlates as indicators of illness severity as well as the helpseeking behaviors that were associated with these diagnostic conditions. A better understanding of discrepancies between objectively assessed clinical needs and the actual use of mental health services will allow for a targeted evaluation of comorbid conditions and integrated treatment interventions.

2. Material and methods

2.1. Sample and procedure

The data were collected within the PsyCoLaus study [19], a substudy of the larger CoLaus randomly selected population-based cohort study [20] of Lausanne, Switzerland. From 2003 to 2006, N = 6734 subjects aged between 35 and 75 years were recruited for the first wave of CoLaus, which was designed to assess the prevalence of cardiovascular risk factors and diseases. Sixty-seven percent of the subjects of the CoLaus study in the age range between 35 and 66 years (n = 5535) accepted the psychiatric exam (PsyCoLaus; see Ref. [19] for a detailed description). Ninety-two percent of them were Caucasians. The gender distribution of the PsyCoLaus sample (47% males) did not differ significantly from that of the general population in the same age range. Although the youngest 5-year band of the cohort was underrepresented and the oldest 5-year band was overrepresented, participants of PsyCoLaus (mean age 50.9; SD = 8.8 years) and individuals who refused participation revealed comparable scores on the General Health Questionnaire (GHQ-12 [21]; French translation [22], which was completed during the somatic investigation (CoLaus)).

For the present analyses, N = 26 subjects were excluded due to missing data on the screening item for traumatic exposure, leading to a final sample of N = 3694 individuals. From those, 53% were females and the mean age was 49.60 years (SD = 8.8). More than half of the sample (52.76%) had basic education (i.e. completion of basic schooling until the age of 16 years, after which an apprenticeship was undertaken or a professional school was attended), 24.69% had higher education (i.e. completion of a school in which a certified profession was taught), and 21.47% had a university-type degree. Forty participants (1.08%) reported that they had not completed compulsory school (i.e. they had left school before the age of 16 years). Socio-economic status (SES) was assessed according to the Hollingshead's index [23]. The mean SES was 3.38 (SD = 1.27), the average sample therefore belonged to the middle class.

The study was approved by the Ethics Committee of the Lausanne University, Switzerland. All participants provided written consent after being informed of the goal and funding of the study.

2.2. Measures

The data of the PsyCoLaus study were derived from the French version [24] of the semi-structured Diagnostic Interview for Genetic Studies (DIGS) [25]. In addition to demographic features, the French version of the DIGS comprises information on a broad spectrum of DSM-IV Axis I and Axis II criteria (including AUD, which comprised both abuse and dependence) as well as on suicide behavior [19]. The PTSD and generalized anxiety disorders sections of the DIGS were based on the relevant sections of the French version [26] of the Schedule for Affective Disorders and Schizophrenia — Lifetime and Anxiety disorder version [27].

The following categories were considered as additional comorbid conditions over lifetime (i.e., independently of whether one was diagnosed with PTSD or AUD): major depressive disorder (MDD), generalized anxiety disorder (GAD), simple phobia, social phobia, agoraphobia, obsessive–compulsive disorder (OCD), panic disorder, antisocial personality disorder, other substance use disorders (SUD; abuse or dependence of cannabis, solvent, hallucinogens, stimulants, cocaine, sedatives, or narcotics), and suicide attempts.

Information on overall helpseeking behavior was based on single items from the DIGS. Thus, questions were asked on whether a participant had sought professional help for emotional problems at any time during his/her life and if so, at what age for the first time. Furthermore, questions were asked on whether a participant was ever admitted to a psychiatric hospital for

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