



Quality of life in veterans with alcohol dependence and co-occurring mental illness



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HIGHLIGHTS

- We compared two groups of veterans with different comorbid conditions.
- We examined how quality of life changed with 12-week AD treatment in the 2 groups.
- Quality of life improved for all veterans regardless of comorbid diagnosis.
- There was no difference in the quality of life between the two groups.
- Abstinence influenced the quality of life.

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ABSTRACT

Quality of life is negatively impacted by diagnosis of mental illness. Those with mental illness report problems in physical, psychological, cognitive, social, and occupational functioning. This study was designed to examine changes in quality of life in veterans with dual diagnoses. All veterans participated in a treatment study designed to treat alcohol dependence with naltrexone, disulfiram, and the combination of naltrexone/disulfiram or placebo for 12 weeks. Quality of life was assessed before treatment and at the end of treatment. Quality of life improved for all veterans and the improvement was more significant for those who abstained from alcohol throughout treatment. Severity of psychiatric symptom was associated with worse quality of life. This study demonstrates the importance of addressing social functioning in veterans with dual diagnosis.

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1. Introduction

Alcohol use disorders are among the most prevalent psychiatric disorders. Data from several epidemiological studies suggest that the lifetime prevalence of alcohol use disorders in the US is around 8% (Hasin, Stinson, Ogburn, & Grant, 2007; Kessler, Chiu, Demler, & Walters, 2005; Regier et al., 1990). Some groups, such as veterans and military personnel, have even higher prevalence rates (10%) (Seal et al., 2011).

Alcohol use disorders are further complicated by high rates of comorbid psychiatric disorders. In a recent, large epidemiological study, the twelve-month prevalence rate of depression among those with alcohol use disorders was 18.85%, and the prevalence rate of anxiety disorders was 17.05% (Grant et al., 2004). Among returning veterans,

the prevalence rate of PTSD from the recent conflicts has been estimated at about 14% (Schell & Marshall, 2008) and is higher when compared to the rate in the general population (4%) (National Comorbidity Study Replication, 2007). The comorbid prevalence rates in those with serious mental illnesses like schizophrenia and bipolar spectrum disorders are even higher ranging from 33.7% in patients with schizophrenia spectrum disorders to upwards of 56% in patients with bipolar I disorder (Brown, Suppes, Adinoff, & Thomas, 2001; Chengappa, Levine, Gershon, & Kupfer, 2000; Hasin et al., 2007; Krishnan, 2005; Merikangas et al., 2008; Mueser et al., 1990). Comorbidity of psychiatric disorders with substance use complicates treatment, increases suffering and impairs the overall quality of life by lowering physical, psychological, cognitive, social, and occupational functioning. For those reasons, in the last few decades there has been an increased interest in using quality of life measures as outcomes in treatment trials.

It has been well established that when compared to the general population those with alcohol dependence (Foster, Marshall, & Peters, 2000a, 2000b; Foster, Powell, Marshall, & Peters, 1999; Morgan, Morgenstern, Blanchard, Labouvie, & Bux, 2003), depression,

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anxiety (Candilis et al., 1999; Katschnig & Angermeyer, 1997; Markowitz, Weissman, Ouelette, Lish, & Klerman, 1989; Rapaport, Clary, Fayyad, & Endicott, 2005; Rubin et al., 2000; Zatzick et al., 1997), and serious mental illness (including bipolar disorder) experience impaired quality of life (Bengtsson-Tops & Hansson, 1999; Gupta, Kulhara, & Verma, 1998; Ponisovsky, Grinshpoon, Lekav, & Ritsner, 2003; Ritsner et al., 2000). In the general population those with mood and anxiety disorders alone had a lower quality of life than those with alcohol dependence alone (Saarni et al., 2007). In clinical samples, a comorbid diagnosis of serious mental illness (Jones et al., 2006), depression or anxiety along with alcohol dependence negatively impacted quality of life (Goldstein & Leavitt, 2008; Khalsa et al., 2008; Saatcioglu et al., 2008; Singh, Matoo, Sharan, & Basu, 2005; Weiss, 2004). Among veterans, the presence of a comorbid psychiatric disorder negatively impacted psychological and social functioning compared to veterans with alcohol dependence alone (Kalman et al., 2004). The existing evidence suggests that diagnosis of PTSD leads to significant impairment in all domains of quality of life, but research in this area is very limited and the impact of comorbid alcohol use disorders on quality of life is unknown at this time.

Improvements in the quality of life have been observed with abstinence among the general population (Foster, Peter, & Marshall, 2000; Foster et al., 1999; Gillet et al., 1991). Among those with dual diagnosis of depression or anxiety and alcohol use disorders, treatment for alcohol use can reduce symptoms of anxiety and depression and improve general functioning (Liappas, Paparrigopoulos, Tzavellas, & Christodoulou, 2002). Improvements in physical health, psychiatric symptoms, support structure and close relationships predicted improvements in quality of life for those with depression/anxiety and alcohol use disorders. The same predictors of improvement have been reported in those with serious mental illness (Drake, Mercer-McFadden, Mueser, McHugo, & Bond, 1998).

There is no single definition of quality of life that has been universally accepted (Gill & Feinstein, 1994) but a broad definition emphasizes the subjective, overall health and well being of an individual. Since a variety of circumstances influence individual's well-being and quality of life is an amorphous construct, there has not been consistency in use of measures to assess the quality of life in different populations. No specific instruments have been developed to measure the quality of life in individuals diagnosed with alcohol dependence (Luquiens, Reynaud, Falissard, & Aubin, 2012) or with depression and anxiety disorders, although the Short-Form Health Survey (SF36) has been most widely used with the latter. Specific quality of life scales have been developed mostly for individuals with schizophrenia. The Quality of Life Scale (QLS) (Heinrichs, Hanlon, & Carpenter, 1984) was developed to evaluate 4 areas of theoretical relevance to schizophrenia although the authors believe the scale has relevance across diagnostic groups (e.g. chronic affective disorders, personality disorders). The areas include: 1) Intrapsychic Foundations (cognitive, motivational and emotional states), 2) Interpersonal Relations (interpersonal and social relationships), 3) Instrumental Role (occupational role, functioning and satisfaction), and 4) Common Objects and Activities (possession of common objects and participation in regular activities).

This study sought to elucidate the impact of alcohol consumption on quality of life among veterans with alcohol dependence and comorbid mental illness. To do that we examined changes in quality of life ratings from baseline to post treatment in veterans who had participated in a 12-week medication treatment trial using disulfiram and/or naltrexone for alcohol dependence. It was hypothesized that (1) all veterans would report improved quality of life after participation; (2) veterans receiving medication would report more improvement than those receiving placebo; and (3) those who abstained from alcohol use would report greater improvements in their quality of life compared to those who did not. The second objective of this paper was to evaluate the impact of alcohol consumption on quality of life among veterans with and without diagnosis of PTSD.

2. Material and methods

2.1. Participants

This study is a secondary analysis (for details of the original project, see Petrakis, Poling, Levinson, Nich, & Rounsaville, 2005) of a project that was conducted at VA Connecticut Healthcare System (West Haven, CT), the VA Central Western Massachusetts Healthcare System (Northampton, MA) and Bedford VA Medical Center (Bedford, MA). The study was approved by the Institutional Review Board at VA Connecticut Healthcare System, Yale University, the Northampton VA and the Bedford VA. The sample consisted of 254 veterans who were receiving outpatient care at these three VA sites. All veterans signed informed consent prior to participation. Veterans met criteria for DSM-IV diagnoses of alcohol dependence and other Axis I disorders as determined by the Structured Clinical Interview for DSM-IV Axis I Disorders, Research Version, Patient Edition (First, Spitzer, Gibbon, & Williams, 1996), and all were abstinent no more than 29 days at baseline assessment. Quality of life information was obtained from 241 veterans using the Quality of Life Scale (QLS) (Heinrichs et al., 1984). Current analyses included all veterans who completed the QLS at baseline and/or at the completion of the 12-week trial. Three veterans had incomplete QLS data (more than 30% missing) and were excluded from the analysis resulting in a sample of $n = 238$. There were no statistically significant baseline differences between veterans who completed the QLS vs. those that did not. The sample of 238 veterans had one or more of the following DSM-IV current diagnoses: schizophrenia ($n = 6$), schizoaffective disorder ($n = 5$), schizophreniform disorder ($n = 3$), bipolar I disorder ($n = 17$), bipolar II disorder ($n = 14$), other bipolar disorders ($n = 2$), depression ($n = 137$), post traumatic stress disorder ($n = 88$), panic disorder ($n = 22$), generalized anxiety disorder ($n = 22$), and cocaine dependence ($n = 50$). Participation was voluntary.

2.2. Procedure

A complete description of the study procedures for the medication treatment trial is provided in Petrakis et al. (2005). All veterans completed a thorough evaluation at study enrollment including a physical examination, laboratory assessments, and a structured interview (Structured Clinical Interview for DSM-IV Axis I Disorders, Research Version, Patient Edition) to establish diagnoses of alcohol dependence and other Axis I disorder. The current use of psychotropic medications was also collected. In addition, information regarding their use of alcohol and other substances was obtained using the Timeline Follow-Back Interview (Sobell & Sobell, 1992). Veterans also completed a self-report questionnaire regarding alcohol use (Alcohol Dependence Scale), psychiatric symptomatology (Brief Symptom Inventory), and provided information on quality of life using the Quality of Life Scale. Upon completion of these baseline assessments, all veterans were randomized to one of four groups for a 12-week trial. Randomization was accomplished at two levels: 1) veterans were openly randomized to disulfiram 250 mg or no disulfiram, and 2) veterans were further randomized to naltrexone 50 mg or placebo in a double-blind fashion. This led to the creation of four groups: 1) naltrexone 50 mg alone, 2) placebo alone, 3) disulfiram 250 mg + naltrexone 50 mg, and 4) disulfiram 250 mg + placebo. At each weekly visit, veterans completed both self-report and clinician-administered measures. Veterans also completed a comprehensive battery of measures at their week 12 visit, including the Quality of Life Scale.

2.3. Measures

2.3.1. Timeline Follow-Back Interview

The Timeline Follow-Back Interview (TLFB) (Sobell & Sobell, 1992) is a method of measuring daily alcohol consumption for 3 months

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