Childhood adversities, bonding, and personality in social anxiety disorder with alcohol use disorder

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ABSTRACT

Social anxiety disorder (SAD) is frequently associated with alcohol use disorders (abuse/dependence). However, there has been little research on the characteristics of this subgroup so far. In the current study we investigated individuals with SAD and comorbid alcohol use disorder (AUD) with regard to socialization experiences and personality.

The sample comprised 410 individuals diagnosed with SAD by the Structured Clinical Interview of DSM-IV. 108 participants with comorbid AUD were compared to 302 participants without comorbid AUD concerning traumatic experiences during childhood and adolescence (Adverse Childhood Experiences Questionnaire; ACE), parental bonding (Parental Bonding Instrument; PBI), and personality (Temperament and Character Inventory; TCI).

MANCOVA with covariates sex and depression displayed that individuals with SAD plus AUD reported significantly more traumatic events during childhood and adolescence, lower levels of maternal care, as well as lower cooperativeness.

Our results highlight that adverse childhood experiences and unfavourable maternal bonding characterize individuals suffering from SAD plus AUD. These experiences might be reflected in a personality-based tendency to distance themselves from others, which corresponds to low scores on the character dimension cooperativeness. A deeper understanding of personality and specific socialization experiences is necessary to develop new treatment options in this clinically challenging subgroup.

1. Introduction

Epidemiological research has demonstrated high rates of comorbid social anxiety disorder (SAD) and alcohol use disorder (AUD) in both clinical samples and in the general population. In the National Epidemiologic Survey on Alcohol and Related Conditions, the lifetime prevalence of comorbid SAD and AUD in the general population was 2.4% (Schneier et al., 2010). In around 80% of comorbid SAD/AUD cases, SAD preceded alcohol dependence, and comorbid status was associated with increased AUD severity and decreased treatment-seeking (Schneier et al., 2010). Furthermore, SAD/AUD comorbidity leads to greater complications relative to SAD alone, with more severe SAD symptoms, higher amount of psychiatric diagnoses, less social support, lower marriage rates, and lower professional status (Thomas et al., 2003; Buckner et al., 2008; Schneier et al., 2010).

Despite these findings, the reasons why some individuals with SAD abuse alcohol and develop comorbid AUD, while others do not remain unclear. Most empirical research has focused on motives and
expectancies concerning current alcohol use, thus strengthening the self-medication hypothesis (Morris et al., 2005; Cludius et al., 2013). In contrast, few data are available concerning other factors with a potential influence on alcohol use in SAD. Specifically, more fundamental causes, rooted in traumatic experiences in childhood and adolescence, may shape specific personality characteristics.

Previous studies have demonstrated a high prevalence of early traumatic life events in individuals with SAD (Bandelow et al., 2004; Eikenaes et al., 2015), and AUD (Brady and Back, 2012). A plausible hypothesis is that even more pronounced psychological trauma will be observable in individuals with comorbid SAD/AUD. Traumatization is frequently associated with inadequate parental care (Breidenstine et al., 2011). In accordance with this, previous studies have reported an ‘affectlessness control’ parenting style (Parker et al., 1979) in individuals with SAD (Parker, 1979; Parker et al., 1997; Eikenaes et al., 2015) and AUD (Joyce et al., 1994). This parenting style is characterized by low care and a high degree of control. Thus, a pronounced manifestation of this parenting style may underlie the development of comorbid SAD/AUD. Pronounced ‘affectlessness control’ is also consistent with a character profile characterized by a tendency to distance oneself from others due to negative experiences of close relationships. This may be reflected in low cooperativeness, as reported in studies of alcohol dependence (Andó et al., 2014).

The aim of the present study was to test the hypothesis that in comparison to individuals with SAD without AUD, individuals with SAD with comorbid AUD: (i) had experienced a significantly higher level of childhood adversity; (ii) perceived both parents as significantly less caring but more controlling; and (iii) report significantly lower scores on cooperativeness, and higher scores on the temperament dimension novelty seeking. The latter mirrors impulsivity and excitability, which underlie substance use disorders in general (Noél et al., 2011; Andó et al., 2014).

2. Methods

2.1. Participants

All participants were recruited within the context of the German research project “Social Phobia Research – Research on SAD”, which commenced in 2012 as a collaboration between the Clinic for Psychosomatic Medicine and Psychotherapy and the Institute of Human Genetics at the University of Bonn, Germany (Forstner et al., 2017). The study was approved by the ethics committee of the University of Bonn, and all participants provided written informed consent prior to inclusion. The inclusion criteria for the present study were: (i) age 18 years or above; (ii) a lifetime diagnosis of SAD, as confirmed by the Structured Clinical Interview for DSM-IV Axis I disorders (SCID-I; First et al., 1997; Wittchen et al., 1997); and (iii) a score of 19 or above in the Social Phobia Inventory (SPIN; Connor et al., 2000; Sosic et al., 2008). The latter criterion was applied in order to ensure that only participants with clinically significant social anxiety were included, since a cut-off score of 19 has been shown to distinguish between persons with SAD and healthy controls, as well as psychiatric patients with diagnoses other than SAD (Connor et al., 2000). Exclusion criteria for the present study were: (i) inadequate German language skills for the completion of study instruments; (ii) difficulties in completing study questionnaires due to somatic and/or mental impairments (e.g., attention and/or language deficits secondary to a history of brain tumor or stroke); (iii) lack of diagnostic interview; (iv) and/or ≥ 90% missing items in one or more of the relevant study questionnaires.

The initial cross-sectional sample comprised 441 eligible participants. Of these, 31 had ≥ 90% missing items for one or more of the relevant study questionnaires. These participants were therefore excluded. Of the residual 410 participants, 108 (26.3%) also met DSM-IV criteria for a lifetime diagnosis of AUD (abuse: n = 58; 14.1%; dependence: n = 50; 12.2%). The demographic characteristics of the study cohort are shown in Table 1. The 410 study participants were recruited via: newspaper advertisements or articles (n = 112; 27.3%); the internet (n = 88; 21.5%); clinical services (outpatients and inpatients) (n = 79; 19.3%); a report on a regional TV/radio channel (n = 60; 14.6%); self-help groups (n = 23; 5.6%); advertisements on notice boards in urban areas (n = 18; 4.4%); cooperation with external clinics (n = 15; 3.7%); outpatient practitioners (n = 10; 2.4%); or unknown source (n = 5; 1.2%).

### Table 1

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Total SAD sample</th>
<th>SAD without AUD</th>
<th>SAD with AUD</th>
<th>Test statistic (p-value)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>n = 410</td>
<td>n = 302</td>
<td>n = 108</td>
<td>χ² = 27.33 (0.000)***</td>
</tr>
<tr>
<td>Female</td>
<td>222 (56.6)</td>
<td>194 (64.2)</td>
<td>38 (35.2)</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>178 (43.4)</td>
<td>108 (35.8)</td>
<td>70 (64.8)</td>
<td></td>
</tr>
<tr>
<td>Age (in years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M (SD)</td>
<td>43.66 (13.60)</td>
<td>42.42 (13.50)</td>
<td>47.14 (13.35)</td>
<td></td>
</tr>
<tr>
<td>Current partnership</td>
<td>n = 396</td>
<td>n = 289</td>
<td>n = 107</td>
<td>t = −3.13 (0.002)**</td>
</tr>
<tr>
<td>Yes</td>
<td>209 (52.8)</td>
<td>158 (54.3)</td>
<td>51 (47.7)</td>
<td>χ² = 1.54 (0.257)</td>
</tr>
<tr>
<td>No</td>
<td>187 (47.2)</td>
<td>131 (45.3)</td>
<td>56 (52.3)</td>
<td></td>
</tr>
<tr>
<td>Completed level of education</td>
<td>n = 393</td>
<td>n = 286</td>
<td>n = 107</td>
<td>χ² = 4.78 (0.097)</td>
</tr>
<tr>
<td>Below high school</td>
<td>157 (39.9)</td>
<td>105 (36.7)</td>
<td>52 (48.6)</td>
<td></td>
</tr>
<tr>
<td>High school</td>
<td>118 (30.0)</td>
<td>89 (31.1)</td>
<td>29 (27.1)</td>
<td></td>
</tr>
<tr>
<td>College level or above</td>
<td>118 (30.0)</td>
<td>92 (32.2)</td>
<td>26 (24.3)</td>
<td></td>
</tr>
<tr>
<td>Ethnicity</td>
<td>n = 388</td>
<td>n = 286</td>
<td>n = 102</td>
<td>Fisher’s exact test = 0.98 (0.601)</td>
</tr>
<tr>
<td>Central European</td>
<td>373 (96.1)</td>
<td>273 (95.5)</td>
<td>100 (98.0)</td>
<td></td>
</tr>
<tr>
<td>West or East European</td>
<td>12 (3.1)</td>
<td>10 (3.5)</td>
<td>2 (2.0)</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>3 (0.8)</td>
<td>3 (1.0)</td>
<td>0 (0.0)</td>
<td></td>
</tr>
</tbody>
</table>

Note: Missing data for current partnership, completed level of education, and ethnicity due to incomplete sociodemographic survey. Data are presented as number of participants and valid percent. Test statistics refer to the comparisons of individuals with SAD without AUD vs. individuals with SAD with AUD.

*** p ≤ 0.001, two-tailed.

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