



Family composition and symptom severity among Veterans with comorbid PTSD and substance use disorders



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HIGHLIGHTS

- Family composition is important to consider for Veterans with PTSD/SUD.
- Children in the home accounted for unique variance in PTSD symptom severity.
- Children in the home did not account for unique variance in SUD symptom severity.
- Care for Veterans with comorbid PTSD/SUD should be family-informed.

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ABSTRACT

Posttraumatic stress disorder (PTSD) and substance use disorders (SUD) frequently co-occur and affect a substantial proportion of military Veterans. Although the impact of parental PTSD and SUD on child development is well-documented, little is known about the influence of family composition on PTSD/SUD symptom severity. The present study investigated children in the home as an independent risk factor for symptom severity in a sample of treatment-seeking Veterans ($N = 94$; 92% male) with comorbid PTSD/SUD. Twenty-seven percent of the sample had minor children (age 18 or younger) living in the home. Veterans with children in the home evidenced significantly higher PTSD symptomatology as measured by the Clinical Administered PTSD Scale (CAPS; $M = 82.65$ vs. $M = 72.17$; $t = -2.18$; $p < .05$), and reported using marijuana more frequently than Veterans without children in the home (34% vs. 13% of past 60 days; $t = -2.35$, $p < .05$). In a multivariate model, having children in the home accounted for unique variance ($\Delta R^2 = .07$) in PTSD severity after accounting for a range of covariates; however, having children in the home did not account for unique variance in substance use. Directions for future research as well as potential clinical implications for parents seeking treatment for PTSD/SUD are discussed.

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1. Introduction

Parenting involves numerous challenges and there is evidence that these challenges are amplified among parents diagnosed with posttraumatic stress disorder (PTSD; Berz et al., 2008; Samper, Taft, King, & King, 2004), substance use disorders (SUD; Bagner et al., 2009), and mental health problems in general (Crnic & Low, 2002; Nicholson et al., 2001). Little is known, however, regarding the family composition of individuals with comorbid PTSD/SUD, and how family composition might influence their clinical profile. The present study was designed, therefore, to preliminarily investigate PTSD and SUD symptomatology

among treatment-seeking Veterans with and without children living in the home.

2. Parental PTSD/SUD and child development: a bidirectional relation?

There is a large body of literature substantiating the adverse impact of parental psychopathology on child development. Children of parents with PTSD are at significantly increased risk for emotional and behavioral problems, including the development of PTSD following trauma exposure, evidenced as early as infancy and continuing into adulthood (Leen-Feldner et al., 2013). Similarly, children of parents with alcohol use disorders are at increased risk for conduct disorder, emotional problems, and SUD (Weitzman & Chen, 2005; Christensen & Bilenberg, 2000). Mechanisms of influence linking parental PTSD, parental SUD, and child outcomes have not been fully explicated, however genetic, physiological, socioeconomic, and parenting (e.g., harsh parenting; diminished sensitivity) influences are implicated (Chemtob & Carlson,

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2004; Glenn et al., 2002; Gold et al., 2007; Koenen, Nugent, & Amstadter, 2008; Yehuda, Blair, Labinsky, & Bierer, 2007). Research demonstrates that successful treatment of parental psychopathology is associated with significant improvements in child emotional and behavioral problems (for meta-analytic findings, see Siegenthaller, Munder, & Egger, 2012), even in the absence of direct treatment of the child (e.g., SSRI treatment for adult depression; couples-based therapy for SUD; Wickramaratne et al., 2011; O'Farell & Schein, 2011).

Data suggest that the relation between adult psychopathology and child development is bidirectional. For example, Lang et al. (1999) and Pelham & Lang (1999) found that, among social non-problem drinking parents, interactions with a confederate child behaving in an oppositional/hyperactive manner resulted in increased amount of alcohol consumed, as compared to social drinking parents interacting with a well-behaving child confederate. In addition, recent research among parents using methamphetamine shows that the number of children living in the home is positively correlated with parental depressive symptoms (Semple et al., 2011). To our knowledge, no studies have examined parenting status, family composition and mental health symptom profile among individuals with comorbid PTSD/SUD. Addressing this gap in the literature is critical to better understand potential avenues to improve treatments for individuals with comorbid PTSD/SUD.

3. Treatment of comorbid PTSD/SUD: does parenting status matter?

It is estimated that up to half of adults seeking treatment for SUD also meet criteria for PTSD (Mills et al., 2005), and that the clinical course of this comorbidity is characteristically more severe and difficult to treat than either disorder alone (Back et al., 2000; Back et al., 2005). Specifically, research has shown poorer treatment outcomes in comorbid patients (compared to those with either disorder alone) related to worse compliance with aftercare (Brady et al., 1994), quicker relapse (Brown, Stout, & Mueller, 1996), and more social and interpersonal problems (Ouimette, Brown, & Najavits, 1998). The self-medication hypothesis (Khantzian, 1985) posits that individuals with PTSD use substances to help mitigate trauma-related symptoms. Waldrop and colleagues (2007) found that individuals with PTSD/SUD are at greater risk of using substances to cope with negative situations (e.g., negative emotions, interpersonal conflict) than individuals with SUD alone. This is particularly relevant for parents given the daily challenges associated with parenting (Breslau, Davis, Peterson, & Schultz, 1997; Chilcoat & Breslau, 1998). Parents with SUD are often aware of the potential for adverse consequences of their substance use on their children, and for some parents children can be a motivating factor for seeking treatment (Richter & Bammer, 2000; Swift, Copeland, & Hall, 1996). There also may be a link between parenting status and treatment response: preliminary data suggest that being the primary caretaker of a child during SUD treatment is associated with less improvement in comorbid psychiatric symptoms following treatment for SUD (e.g., depression and anxiety; Stewart, Gossop, & Trakada, 2007). Thus, it is important to better understand the parenting context of individuals seeking treatment for comorbid PTSD/SUD.

The present study aimed to (1) characterize the family home environment with regard to parental relationship status (e.g., married, separated, cohabitating), number and ages of children, and biological status of children (i.e., whether or not children are biological children), and (2) investigate whether or not, and to what extent, having children in the home accounts for independent variance in PTSD and SUD symptomatology among Veterans with PTSD/SUD. We also undertook exploratory aims related to investigating number and age of children and symptom severity, as well as potential differences on family-related items of a measure of addiction severity for those with vs. those without children in the home. We hypothesized that participants with children living in the home would report significantly higher substance use and symptoms of PTSD than parents

without children in the home. The current study focuses on children living in the home as opposed to having children (i.e., minor or adult children outside of the home) as we based our hypothesis on the impact that having children present in the home might have on daily schedules, responsibilities, and stressors, all of which may significantly relate to symptom severity.

4. Method

4.1. Participants

Participants were 94 treatment-seeking Veterans (92% male; 52% Caucasian, 45% African American) completing a baseline interview as part of a randomized controlled trial (RCT) targeting the integrated behavioral treatment of Veterans with comorbid PTSD/SUD. Inclusion criteria for the RCT included: (1) Veteran, Active-duty Military, Reservist, or member of the National Guard; (2) aged 18–65; (3) meet DSM-IV (APA, 1994) diagnostic criteria for current (i.e., past 6 months) PTSD and have a score of 50 or higher on the Clinician Administered PTSD Scale (CAPS; Blake et al., 1995); (4) meet DSM-IV diagnostic criteria for current (i.e., past 6 months) substance use disorder and report substance use during the past 90 days; and (4) speak fluent English. Exclusion criteria included: (1) current or history of psychotic or bipolar affective disorders; (2) active suicidality or homicidality; (3) current eating disorder or dissociative identity disorder; (4) participation in ongoing PTSD or SUD treatment; and (5) organic mental syndrome as indicated by a Mini Mental Status Exam (Folstein, Folstein, & McHugh, 1975) score ≤ 21 . A total of 117 potential participants attended a baseline interview, and the 94 participants retained in the present analysis represent those with complete baseline data on variables of interest. The large majority (97.9%) of the sample were Veterans or inactive Reservists, and 2.1% were active military.

4.2. Procedures

Potential participants were initially screened by telephone and those meeting preliminary eligibility criteria were invited to complete a comprehensive baseline assessment in person. Participants were recruited using a combination of newspaper and internet advertisements and flyers from a local Veterans Affairs Medical Center, treatment clinics at a large medical university, and other local mental health clinics and universities. All study procedures were IRB-approved and participants provided informed consent prior to participation. Participants received \$60 for completing the baseline assessment.

4.3. Measures

4.3.1. Demographic information

Demographic information was collected using a self-report questionnaire designed for the present study. In addition to basic demographic information (see Table 1), participants listed the ages of their children, identified whether each child was their biological child, and indicated whether the child(ren) lived in the home.

4.3.2. Clinician Administered PTSD Scale (CAPS; Blake et al., 1995)

The CAPS assesses past 30-day symptom frequency and severity across PTSD symptoms based on DSM-IV criteria and is considered the “gold standard” in the assessment of PTSD. Items are rated on a scale from 0 to 4, ranging from “none of the time” to “all of the time” for frequency and from “absent” to “extreme/incapacitating” for severity items. Severity scores reported in the present study represent sums across both frequency and severity items (obtained range: 21–115) and internal consistency (Cronbach's alpha) was .92 in the present sample. The life events checklist portion of the CAPS was used to assess lifetime exposure to traumatic events.

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