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Lifetime PTSD and quality of life among alcohol-dependent men: Impact of childhood emotional abuse and dissociation

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ABSTRACT

The aim of this study was to investigate the impact of lifetime posttraumatic stress disorder (PTSD), dissociation and a history of childhood trauma on quality of life (QoL) among men with alcohol dependency. A consecutive series of alcohol-dependent men ($N=156$) admitted to an inpatient treatment unit were screened using the Michigan Alcoholism Screening Test, the Clinician Administered PTSD Scale, the Dissociative Experiences Scale, and the Childhood Trauma Questionnaire. QoL was assessed using the Medical Outcomes Study Short-Form 36-item health survey. Fifty (32.1%) patients had lifetime diagnosis of PTSD. Besides problems related to severity of alcohol use, the lifetime PTSD group was impaired on several physical and mental components of QoL. While the lifetime PTSD group and remaining patients did not differ on reports of childhood trauma and dissociation, in lifetime PTSD group, dissociative patients had higher scores of childhood emotional abuse than those of the non-dissociative patients. In multivariate covariance analysis, both dissociation and lifetime PTSD predicted impairment in physical functioning, general health, vitality, and mental health components of QoL. Among alcohol-dependent men with lifetime PTSD, a history of childhood emotional abuse contributes to impairment of QoL through its relationship with dissociation.

1. Introduction

Alcohol-dependent subjects have lower quality of life (QoL) compared to the general population and patients with chronic health problems (Donovan et al., 2005). QoL is an important component of treatment outcome in alcohol dependency (Donovan et al., 2005; Saatcioglu et al., 2008), because it deteriorates significantly on prolonged relapse (Foster et al., 2000). Despite possible improvement during remission periods following treatment, it is unlikely that QoL of alcohol-dependent individuals becomes equal to or exceeds that of the normative groups (Donovan et al., 2005).

Psychiatric comorbidity is one of the factors that contribute to impairment in health-related QoL in alcohol-dependent patients (Foster et al., 1999). Among others, high prevalence rates of lifetime posttraumatic stress disorder (PTSD) have been documented in this population covering a range of 36–52% (Breslau and Davis, 1992; Kessler et al., 1995). In Turkey, rates of lifetime PTSD among alcohol-dependent inpatients range between 26.8% and 31.0% (Kural et al., 2004; Evren et al., 2006a). Compared to patients with alcohol use solely, those with both alcohol use and PTSD respond to treatment less favorably, relapse faster, take more alcohol during drinking days, and experience more heavy drinking days in post-treatment period (Jacobsen et al., 2001; Brown et al., 1995, 1999; Ouimette et al., 1999; Read et al., 2004). Among patients with alcohol abuse, PTSD is associated with more social, psychological, medical and occupational impairment, poor treatment outcome including worse prognosis on substance use, and a higher rate of utilization of inpatient drug treatment (Brady et al., 1994; Brown et al., 1995; Ouimette et al., 1997, 1998; Najavits et al., 1998). Consequently, coexistent PTSD and alcohol misuse affect QoL adversely both in adults (Warshaw et al., 1993) and adolescents (Clark and Kirisci, 1996).

Subjects with childhood maltreatment history also have significant and sustained losses in health-related QoL in adulthood (Corso et al., 2008). In a recent study, aged (≥60) participants who had experienced either childhood sexual or physical abuse were in greater risk (risk was higher for whom reporting both types of abuse) for poor physical and mental health, after adjustments (Draper et al., 2008). One large study covering members of a health maintenance organization yielded that adverse childhood experiences were associated with ever having used alcohol and with an earlier age of onset of alcohol use (Dube et al., 2006). Childhood trauma is reported by alcohol-dependent patients also frequently and has been proposed to have negative impact on the course of the disorder (Langeland et al., 2004, Evren et al., 2006b), particularly among those with concurrent PTSD (Schumacher et al., 2006). Nevertheless, in alcohol-dependent patients and among men in

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particular, childhood sexual trauma was associated with comorbid PTSD (Langeland et al., 2004).

A clinical variable related to both childhood trauma and PTSD is dissociation (Breh and Seidler, 2007). Childhood trauma has been put forward as one of the main predictors of dissociation in the community as well as in clinical samples (Gershuny and Thayer, 1999; Chu and Dill, 1999) including patients with alcohol and/or substance use disorders (Zlotnick et al., 1997; Evren et al., 2007). Dissociation seems to mediate the relationship between childhood maltreatment and severity of PTSD (Twaite and Rodriguez-Srednicki, 2004). Interestingly, a dissociative subtype of PTSD has also been proposed that was associated with a history of childhood abuse and/or neglect as a co-factor alongside the index traumatic event leading to PTSD in adulthood (Waelde et al., 2005; Ginzburg et al., 2006; Lanius et al., 2010). A considerable proportion of treatment-seeking alcohol dependents exhibit elevated levels of dissociative symptoms (Dunn et al., 1993; Wenzel et al., 1996; Evren et al., 2007). As expected, childhood emotional and sexual abuse and neglect were more frequent among alcohol dependents with a dissociative disorder than those without (Evren et al., 2007).

A follow-up of severely injured accident victims 12 months after trauma documented the negative impact of PTSD on QoL (Baranyi et al., 2010). Although high scores of dissociation in the PTSD group were demonstrated, no further inquiry was conducted on a relationship between dissociation and impaired QoL. Thus, going one step further, the present study was aimed at evaluation of potential relationships of lifetime diagnosis of PTSD, childhood psychological trauma, and dissociation with impaired QoL among alcohol-dependent men. We hypothesized that alongside lifetime diagnosis of PTSD, a history of childhood trauma and chronic dissociation contributed to impaired QoL additionally. We preferred to focus on lifetime rather than a current PTSD diagnosis, because we wanted to inquire chronic impact of traumatization. Nevertheless, to inquire clues about its differences from lifetime PTSD, we compared patients with current PTSD with the remaining patients on scores of childhood trauma and dissociation as well. In order to eliminate any confounding effect, severity of the alcohol-related problems was assessed and controlled as a variable.

2. Methods

2.1. Participants and procedures

The study was conducted in Bakirkoy State Hospital for Psychiatric and Neurological Diseases, Alcohol and Drug Research, Treatment and Training Center (AMATEM) in Istanbul between January 1th and December 31th, 2007. AMATEM is a specialized center for substance use disorders with an 84-bed inpatient unit accepting patients from all over Turkey. The Ethical Committee of the hospital approved the study. Written informed consent was obtained from all participants after the study protocol was thoroughly explained.

One hundred and eighty consecutively admitted alcohol-dependent male inpatients without history of any other substance abuse were considered for participation in the study. All participants fit the DSM-IV diagnostic criteria for alcohol dependence. Exclusion criteria were illiteracy, mental retardation or cognitive impairment, and comorbid psychotic disorder. Five patients were excluded due to illiteracy and three patients due to cognitive deficits. Although none of the patients refused to participate in the study, 16 patients were excluded because they left some parts of the scales unfilled, did not give the forms back or left the treatment program early; i.e. before administration of assessment instruments. Among 180 patients that were suitable for the study, a total of 156 subjects (86.7%) participated in the study. Interviews with the study group were conducted following completion of the detoxification period, i.e. 4–6 weeks after the last day of alcohol use.

2.2. Assessment instruments

A semi-structured socio-demographic history form was conducted to all patients. Besides clinical assessment, the diagnosis of alcohol or drug dependence in each participating patient was made using the Structured Clinical Interview for DSM-IV (SCID-I) (First et al., 1997), Turkish version (Corapcioglu et al., 1999), conducted by a trained interviewer (CE).

2.2.1. Clinician Administered PTSD Scale

The CAPS is a reliable structured interview designed to assess symptoms of PTSD for frequency and intensity (Blake et al., 1995; Weathers et al., 2001). Being considered as the "gold standard" for assessment of PTSD, CAPS has excellent psychometric properties and utility as a diagnostic instrument (Weathers et al., 2001). Severity of the disorder is computed as the sum of the frequency and intensity scores. A frequency score of "1" and an intensity score of at least "2" were sufficient for a symptom to be counted.

2.2.2. Dissociative Experiences Scale

The DES is a 28-item self-report scale (Bernstein and Putnam, 1986). Respondents are asked to rate various dissociative experiences that are occurring in their daily life when they are not under the influence of alcohol or drugs. The Turkish version of the scale has reliability and validity as high as its original form (Yargic et al., 1995) with a good Cronbach's alpha (0.94) in the present study as well. There is also a taxon form of the scale (DES-T) derived from eight of the original items concerning dissociative amnesia and fugue, depersonalization and derealization experiences, and identity confusion and auditory verbal hallucinations. These items are determined to discriminate pathological dissociation from normative one, which is limited to experiences of heightened absorption ability. Taxometric analysis of these items yielded a high probability that an individual is in one of two discrete categories; normal or suffering from pathological dissociation (Waller et al., 1996). Cronbach's alpha was 0.86 for DES-T in the present study.

2.2.3. Michigan Alcoholism Screening Test

The MAST was used in assessment of the severity of dependence (Gibbs, 1985). It is a rapidly used and effective screening tool for lifetime alcohol-related problems and alcoholism. MAST consists of 25 brief true–false items that are to be self-administered in approximately 10 min. Scoring is accomplished after reverse scoring 4 of the 25 items and assigning weighed scores. These weighed scores are then summed; the sum represents a total score reflecting severity of alcohol-related problems. The Turkish version of the MAST has been proved as valid and reliable (Coskunol et al., 1995). The Cronbach's alpha was 0.74 in the present study.

2.2.4. Childhood Trauma Questionnaire

The CTQ (Bernstein et al., 1994, 1997) is a retrospective self-report instrument that inquires traumatic experiences during childhood and adolescence. It assesses five types of childhood trauma: emotional abuse, emotional neglect, physical abuse, physical neglect and sexual abuse. CTQ has excellent test–retest reliability and convergent validity (Bernstein et al., 1994, 1997). It comprises 28 items. Each item is rated from 1 (never) to 5 (very often). Scores range from 5 to 25 for each type of trauma and 25 to 125 for the total trauma score. The Turkish version of CTQ has been used in clinical studies successfully (Sar et al., 2004).

2.2.5. The Short-Form 36

The SF-36 is a so-called generic QoL instrument, which has been originally derived from the Medical Outcome Study (MOS) (Narud and Dahl, 2002). The SF-36 consists of the following eight scales with 36 items (Ware and Sherbourne, 1992): General Health, Physical Functioning, role limitations due to physical health (Role Physical), Bodily Pain, Mental Health, role limitations due to emotional problems (Role Emotional), Energy Fatigue and Social Functioning. Internal consistencies ranged from 0.62 to 0.97 (Ware and Sherbourne, 1992). The raw scores for each of the 8 subscales span from 0 to 100, with 0 representing worst and 100 representing best possible QoL status. The general health, vitality, and mental health subscales differ from the 5 other subscales in that they are bipolar. Here, a score of 100 does not denote a mere absence of problems but positive health states (e.g., happiness, pep, and well-being). The SF-36 was not specifically developed for psychiatric patients but was defined as a generic instrument for medical outcome measurement. In the present study, QoL was measured using the Turkish version of the SF-36 (Kocyigit et al., 1999). For the initial assessment, we used the SF-36 version referring back to the last 4 weeks before hospital admission.

The MOS-SF-36 presents good criteria for reliability and validity in alcohol-dependent patients (Daeppen et al., 1998). Although there are other scales such as EQ-5D, which is short and valid in alcohol dependents for evaluating QoL (Günther et al., 2007), MOS-SF-36 is the only instrument validated in Turkish population for this purpose.

2.3. Procedure

The study consisted of two phases. In the first phase, all patients completed the socio-demographic form. One psychiatrist (E.D.) administered Clinician Administered PTSD Scale (CAPS) and collected these data. The interviewer only knew that patients were alcohol dependent but was blind to the patients' other diagnoses. In the second phase of the study, two psychiatrists (R.C. and M.D.) administered the other self-rating scales used in the present study and collected these data. These interviewers were blind to the patients' CAPS scores and their diagnoses, other than alcohol dependency.

2.4. Statistical analyses

Categorical variables were compared by means of the chi-square statistics. We used Student's *t* test to compare the groups on continuous variables and Mann Whitney *U* when these variables were not normally distributed. Multivariate analysis of covariance was used to identify factors independently associated with QoL. For all statistical analysis *P* values were two-tailed and differences were considered significant at $P<0.05$.