Childhood trauma in treated alcoholics. Prevalence and relevance for clinical impairment
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General Introduction

1.1 Background issues

This chapter describes the contextual information relevant to the central theme of this thesis: Is childhood trauma, in particular physical and sexual abuse, frequently reported in treated adult alcoholics and does it matter, i.e. do traumatized patients have a more severe clinical profile with respect to their alcohol problems and psychiatric problems than non-traumatized patients. The intent of this chapter is to provide the scientific foundation for understanding the relevance of exploring these issues and to integrate the information into the central research questions. After a brief description of the definitions and prevalence of alcohol use disorders and of alcoholics who seek treatment, this chapter outlines empirical and theoretical issues regarding associations between childhood trauma, alcohol use disorders, and other psychiatric disorders.

1.1.1 Alcohol use disorders: diagnostic criteria, prevalence and admissions to treatment

In diagnostic schemes, like the Diagnostic and Statistical Manual of Mental Disorders (DSM), two different alcohol use disorders are distinguished: alcohol abuse and alcohol dependence. The diagnostic criteria for alcohol abuse focus on alcohol-related problems, approximating the more general term “problem drinking”. In terms of the DSM-III-R (APA, 1987), the classification system used in this thesis, a diagnosis of alcohol abuse requires that an individual demonstrates either a pathological drinking pattern characterized by continued drinking despite a persistent or recurrent social, occupational, psychological, or physical problem that was caused or exacerbated by drinking, or recurrent drinking in situations where alcohol use was hazardous, such as driving while intoxicated. A diagnosis of alcohol dependence requires fulfillment of at least three of the nine diagnostic criteria for dependence, including both traditional signs of physical dependence (e.g. tolerance and withdrawal) and more psychological aspects of dependence (e.g. inability to abstain, craving,
importance of drinking in one’s life). A dependence diagnosis indicates that a severe alcohol use disorder has developed. In addition to these diagnostic criteria, it is important to acknowledge that alcohol use disorders are associated with significant medical morbidity and mortality.

According to a recent Dutch national survey among the general population aged 18-64 years (Bijl et al., 1997, 1998), DSM-III-R alcohol use disorder had a lifetime prevalence of 17.2%, a 12-month prevalence of 8.2%, and a one-month prevalence of 5.2%. To put these figures in perspective, alcohol use disorders rank with mood and anxiety disorders among the top three psychiatric disorders in the Netherlands. Males met criteria for an alcohol use disorder about 4.5 times more often than females: lifetime prevalence alcohol abuse was 19.3% for men and 3.9% for women, lifetime prevalence alcohol dependence was 9% for men and 1.9% for women. These findings are in line with the literature, consequently indicating that alcohol use disorders are male-dominated disorders (Kessler et al., 1994; Grant, 1996; Bijl et al., 1997).

Of the individuals with current diagnoses of alcohol use disorders, only about 10% are annually admitted to treatment for alcohol problems. For example, in the year 2000 about 3.5% of individuals with current alcohol abuse (+ 9,000 persons) and about 7% of current alcohol-dependent individuals (+ 20,000 persons) were admitted to inpatient and outpatient alcohol treatment services as well as to general hospitals due to alcohol-related problems in the Netherlands (Nationale Drug Monitor: NDM, 2000, 2001). These data are consistent with epidemiological research indicating that only a minority of alcohol abusing or alcohol-dependent individuals seeks help (Grant, 1996; Sobell et al., 1996; Wu et al., 1999; Bijl & Ravelli, 2000) and that recovery often takes place without therapeutic assistance (Grant, 1996; Sobell et al., 1996; Vaillant, 1996). Concerning utilization of alcohol treatment services, men outnumber women in admissions to treatment. In 2000, for instance, three quarters of the admissions to Dutch outpatient alcoholism treatment concerned men (NDM, 2000, 2001). The preponderance of men in alcohol treatment services is explained by the fact that alcohol use disorders are evidently male-dominated disorders. No significant gender differences in enrollment in inpatient and outpatient alcohol treatment services were reported in two Dutch studies (Raat, 1987; Bannenberg, 1988). Whether females seek alcohol treatment at a younger age or at the same age as males is not clear (see Lammers & Schippers, 1991), however, males in their 30s and 40s are in the majority within Dutch
alcoholism treatment populations (Knibbe & Meyers, 1988). Those individuals with an alcohol use disorder who ever seek treatment are likely to do so after a long period of a continuing downward spiral of difficulties, including social and interpersonal impairments, development of tolerance and alcohol-related abstinence syndromes as well as more serious medical problems (Bucholz et al., 1992; Schuckit et al., 1995a, 1998a; Raimo et al., 1999).

Furthermore, alcoholics who seek treatment have more severe alcohol symptoms than those who do not enter treatment (Bannenberg, 1988; Bucholz et al., 1994; Dawson, 1996; Grant 1996), implying that alcohol dependence is far more prevalent than alcohol abuse in treatment-seeking samples. For example: in the year 2000 80% of the admissions to Dutch inpatient alcohol treatment facilities concerned alcohol dependence, 10% concerned alcohol abuse, and 10% concerned other alcohol-related problems (NDM, 2000, 2001). In addition, treated alcoholics may have more severe alcohol dependence compared to untreated alcohol-dependent individuals (e.g. Caetano, 1991; Bucholz et al., 1994). However, it has been repeatedly demonstrated that dependence severity per se is not a good predictor of treatment-seeking for alcoholism (True et al., 1996). Besides, persons who enroll in alcohol treatment programs are frequently poly substance users, mostly reporting use of alcohol with daily use of benzodiazepines (sedatives, sleeping pills) (Bannenberg, 1988).

1.1.2 Treatment-seeking adult alcoholics: comorbid psychiatric disorders

It has been widely recognized that alcohol use disorders and other mental disorders tend to occur within the same individual ("comorbidity"), a phenomenon found in both treated and untreated adult alcoholics (e.g. Ross et al., 1988; Regier et al., 1990; Kessler et al., 1997a). Among the most prevalent comorbid disorders in alcoholics are affective disorders, anxiety disorders, other psychoactive substance use disorders, and antisocial personality disorder (e.g. Helzer & Pryzbeck, 1988; Regier et al., 1990; Tómasson & Vaglum, 1995). Although psychiatric comorbidity is common among alcoholics from the general population (e.g. 47% had at least one other lifetime psychiatric disorder in Helzer & Pryzbeck, 1988), it is even more common in samples of treated alcoholics (e.g. 84% in Ross et al., 1988).

The study of comorbid psychiatric disorders among treatment-seeking alcoholics has become a topic of growing interest because of its clear impact on course and treatment outcome: alcoholic patients with comorbid disorders tend to have poorer outcomes and
follow a more chronic and treatment-resistant course than those without comorbidity (e.g. Schuckit, 1985). In addition, not only the presence of other psychiatric disorders, but also the severity of both alcohol symptoms and psychiatric comorbidity have been shown to affect the outcome of alcoholism treatment in a negative way (e.g. Booth et al., 1991). The high prevalence of comorbidity of alcohol use disorders and other psychiatric disorders has given rise to the formulation of hypotheses regarding the underlying mechanisms of this comorbidity.

The nature of the associations between alcohol use disorders and comorbid psychiatric disorders, however, remains controversial. Generally, it is acknowledged that artifacts such as chance and sampling effects do not play a major role in the observed high psychiatric comorbidity rates in treated alcoholics: The observed comorbidity rates in samples of alcoholics are greater than would be expected by chance, given the base rates of the disorders; and, the higher than expected comorbidity rates found in population samples suggest that the observed substantial comorbidity rates in alcoholism treatment samples are not only due to the fact that the presence of multiple disorders may increase the probability to enter treatment ("Berkson’s bias"; Berkson, 1949). However, if clinicians are inclined to recommend alcoholism treatment as the priority for their comorbid patients versus treatment for other psychiatric disorders, referral bias could account for the high comorbidity rates.

Acknowledging that artifacts do not seem to play a major role in the co-occurrence of psychiatric disorders in treated alcoholics, the various pathogenic models which have been generated for the phenomenon of comorbidity most commonly assume that the association between alcoholism and other disorders can be explained by: (1) a causal relationship of the disorders, focusing on the question whether the psychiatric symptoms are cause or consequence of alcohol problems, or (2) a shared underlying etiologic factor. Regarding the first explanation, for instance, one disorder may be causally secondary to the other, as when individuals self-medicate with alcohol to mask or reduce psychiatric symptoms. Such a causal relationship may sufficiently explain the association of two psychiatric disorders, however, an additional explanation for comorbidity claims that both disorders may share common etiologic factors, and therefore, the two disorders co-occur at greater than chance frequency. An example of this latter explanation is a biopsychosocial model assuming that alcohol use disorders and other psychiatric disorders share etiological or risk factors (e.g. Zucker & Gomberg, 1986). The concept of a shared etiology is most frequently illustrated by
the role of a common genetic predisposition that may underlie both the index and comorbid condition. Another example of shared etiologic factors includes environmental risk factors such as, childhood trauma (e.g. sexual and physical abuse, early parental loss), witnessing domestic violence, childhood neglect, parental dysfunction, and adult violent victimization experiences. Research has shown that such factors are associated with an increased risk for later psychopathology (see Draijer, 1990).

The present study explores the role of environmental risk factors, in particular childhood trauma and neglect, in both alcohol problems and psychiatric comorbidity in adults. If alcohol use disorders and additional psychiatric problems share common developmental pathways involving childhood trauma, than a history of trauma should be associated with both increased alcohol problems and increased psychiatric comorbidity. The three central themes of the thesis are: (1) the prevalence of physical and sexual assault in treated adult alcoholics; (2) the role of childhood trauma, in particular physical and sexual abuse in the development of alcohol use disorders and in the drinking problem severity in treated alcoholics; and, (3) the role of childhood trauma in Axis I comorbidity in treatment-seeking alcoholics.

Before describing the state of the art of empirical research in these three areas, a short overview of some relevant theoretical issues regarding associations between (childhood) trauma, alcohol use disorders, and psychiatric comorbidity is presented. For clearness’ sake, the research presented in this thesis started in 1993. In the subsequent four sections, including overviews of the state of the science – theoretically and empirically – of the relevant literature, the year 1993 has been taken as point of reference. Descriptions of scientific developments during the course of the study are included in Chapters 2 through 8. Recent findings from the neurosciences which provide biological plausibility of the detriments of childhood trauma and neglect are addressed in Chapter 8.

1.1.3 Childhood trauma, alcohol use disorders, and other psychiatric disorders: relevant theoretical issues

The notion that stress causes or exacerbates psychopathology is one of the cornerstones of the biopsychosocial model of mental illness. Compelling evidence from a variety of studies suggests that early life stress, and in particular childhood physical and sexual abuse
constitutes a major risk factor for the development and persistence of mental disorders. In 1993, numerous reviews already had been published describing the multiple domains of functioning affected by childhood abuse and neglect (e.g. Brown & Finkelhor, 1986; Wolfe, 1987; Wyatt & Powell, 1988; Draijer, 1990; Beitchman et al., 1992). This literature indicated that childhood trauma is associated with a variety of negative mental health outcomes such as anxiety, depression, posttraumatic stress disorder, suicidal behaviors, dissociation, substance abuse and personality disorders (mainly borderline). The growing recognition that the majority of childhood abuse survivors manifest a constellation of symptoms rather than one specific diagnosis, has led to the suggestion of a spectrum of posttraumatic symptoms, including anxiety, depression, somatization, dissociation, deficits in impuls control and substance abuse (e.g. van der Kolk & van der Hart, 1989; Herman, 1992a,b). Profound changes in affect regulation and self-identity have been observed in traumatized children. It is speculated that prolonged, repeated trauma, particularly if this occurs early in the life cycle, interferes with the development of self-regulatory processes and with the capacity to manage subsequent stresses (e.g. Herman & Van der Kolk, 1987; Terr, 1991; Herman, 1992a,b). Theoretical conceptualizations of the effects of childhood trauma have identified tension reduction defenses or avoidance strategies against painful affect as for example, dissociation, self-mutilation, impulsivity and substance abuse, as a key characteristic of trauma survivors (e.g. van der Kolk & van der Hart, 1989; Herman, 1992a,b). Briere (1989) has termed the phenomenon of substance use as coping strategy to rapidly reduce negative emotions in adults molested as children “chemical avoidance”.

An often applied model of excessive alcohol consumption in individuals in general and in traumatized individuals in particular is one associated with the self-medication hypothesis of substance use disorders (Khantzian, 1985). According to this hypothesis, alcohol or drug abuse begins as a partially successful attempt to assuage overwhelming painful affective states or to experience or control absent or confusing emotions. Individuals predisposed by biological or psychological vulnerabilities discover the powerful reinforcing effects of certain substances in a context of self-regulation vulnerabilities, primarily difficulties in regulating affects, self-esteem, relationships, and self-care. Earlier, Pierre Janet suggested that an individual may develop a substance use disorder if this person falls into a depressive state due to a traumatic experience or other form of overburdening, as well as experiences the stimulating effect of alcohol and discovers that the need for stimulation is
satisfied by alcohol (see Van der Hart & Op den Velde, 1992, page 117). Self-medication with alcohol is the most frequently cited explanation for reported high rates of alcohol abuse in adults (mostly Vietnam veterans) with posttraumatic stress disorder (PTSD), suggesting that alcohol is abused to control their traumatic memories c.q. reduce anxiety, sleep disturbances, nightmares, and other intrusive posttraumatic stress symptoms (e.g. Lacoursiere et al., 1980; Jellinek & Williams, 1987; Keane et al., 1988). In the absence of other self-soothing capacities, external means of affect regulation through substances such as alcohol may effectively dampen the posttraumatic problems for some time. However, chronic drinking as self-medication for PTSD symptoms may result in tolerance and in a need to increase the amount of alcohol consumed to maintain symptom reduction. Withdrawal from alcohol may then increase the risk of an exacerbation of trauma-related symptoms (e.g. Lacoursiere et al., 1980; Root, 1989; Abueg & Fairbank, 1992; Kofoed et al., 1993).

Concerning traumatic exposure in childhood, the assumption is that the child abuse-alcohol problem relation is, at least partially, mediated by the presence of trauma-related disorders. It is suggested that early physical and sexual abuse predispose individuals to develop psychiatric conditions, with PTSD being only one of the several possible long-term outcomes that are associated with excessive alcohol use. For example, abuse survivors may use alcohol to alleviate painful intrusive memories and anxiety, to handle negative feelings toward the self and others that are generated by the abuse experiences, to express painful affect such as rage and sadness, to escape from or to manage dissociative symptoms, to mediate sexual problems, or to ‘fit in’ social activities (e.g. Briere & Runtz, 1987; Evans, 1988; Root, 1989; Hurley, 1990; Kluft, 1991; Herman, 1992a). In addition, it has been suggested that these perceived effects of alcohol and (non)drinking motives may be important in distinguishing differences between adult abuse survivors who develop alcohol problems and those who do not, with the latter group avoiding regular use of alcohol because of fear of losing control (Hurley, 1990).

In addition, in his self-medication theory of substance abuse, Khantzian (1985) suggested that the selection or preference for the abuse of certain psychoactive substances is based on their specific psychotropic effects. More particularly, trauma researchers have speculated that traumatized individuals with impaired capacities for self-regulation may preferentially use analgesic, numbing substances such as opiates, benzodiazepines, and alcohol (e.g. Kosten & Krystal, 1988; Herman, 1992a; Charney et al., 1993). It is suggested
that these substances may be preferred, given their interaction with opioid receptors in the endogenous opioid system, a system that is significantly impacted by physiologic changes produced by severe trauma (Kosten & Krystal, 1988; Charney et al., 1993). The use of numbing substances is viewed as an attempt to self-medicate emotional dysregulation by attenuating intense emotions and hyperarousal symptoms associated with trauma exposure (Kosten & Krystal, 1988; Herman, 1992a; Charney et al., 1993).

1.1.4 Prevalence of physical and sexual assault histories in treated adult alcoholics

Traditionally, alcohol research had focused mainly on men (see Wilsnack & Beckman, 1984; Lammers & Schippers, 1991; Gomberg & Nirenberg, 1993). In this literature, no attention was paid to physical or sexual victimization. However, following the Vietnam war, there was a greater focus on the importance of traumatic stress, as opposed to other factors such as personality, in the development of psychopathology, including in particular research on the development of alcohol use disorders in male veterans (mostly Vietnam) with combat-related PTSD (e.g. Lacoursiere et al., 1980; Sierles et al., 1983; Blum et al., 1984; Druley & Pashko, 1988). In line with these scientific developments, the first studies examining the prevalence of childhood abuse in male alcoholics were based on samples of inpatients in Veteran Administration hospitals (Kroll et al., 1985; Schaefer et al., 1988). From the 1970s on more studies exclusively on female alcoholics were conducted (see Wilsnack, 1984). It was through these studies that a growing appreciation of the importance of sexual issues in female alcoholics appeared, and that evidence began to accumulate indicating that many of these women reported sexual abuse histories (Benward & Densen-Gerber, 1975; Hammond et al., 1979; Evans & Schaefer, 1980; Hayek, 1980; Murphy et al., 1980).

In the 1980s and early 90s, awareness of assault histories in substance abusers, in particular sexual victimization in female addicts, became increasingly more evident in the addiction literature (e.g. Cohen & Densen-Gerber, 1982; Coleman, 1982, 1987; Skorina & Kovach, 1986; Evans & Schaefer, 1987; Ladwig & Andersen, 1989; Copeland & Hall, 1992; Fullilove et al., 1992, 1993; Karsten, 1993). Regarding adult female alcoholics, in 1993 the observed rates of childhood abuse in women seeking alcoholism treatment or attending meetings of Alcoholics Anonymous ranged from 4% to 50% for incest, from 13% to 74% for
any kind of sexual abuse, and from 40% to 71% for physical abuse (Hayek, 1980; Wilsnack, 1984; Covington, 1986; Scherotzki-Hanninger et al., 1986; Kovach, 1986; Downs et al., 1987; Miller et al., 1987, 1993; Nadeau, 1990; Lammers, 1991). Also, high prevalence rates had been reported for both lifetime sexual assault experiences (54%: Murphy et al., 1980; 68%: Lammers, 1991) and spousal violence (44% being slapped, 60% being pushed or grabbed, 27% being kicked, hit, or hit with a fist, and 24% being beaten up: Miller et al., 1989). Concerning treated male alcoholics, in 1993 only childhood physical abuse rates were available, ranging from 13% (Kroll et al., 1985) to 31% (Schaefer et al., 1988) in combat trauma populations (veterans).

More particularly in the Netherlands, evidence of high sexual victimization rates among female hard drug users and growing awareness of limitations of existing treatment services for this group had resulted in the Rotterdam area in project ‘Transit’ focusing on treatment improvement for female addicts with sexual assault histories (Brug & Croes, 1993). Knowledge about physical and sexual victimization rates in treated adult female alcoholics was limited: In an alcohol clinic for women, one out of three clients admitted in the year 1987 reported incest experiences (see Elfring & Mol, 1989), whereas in a sample of 19 female alcoholic inpatients 47% reported childhood sexual abuse experiences and 68% reported sexual assault experiences during their lives (Lammers, 1991). Though these observed childhood sexual abuse rates are higher than found among women in the Dutch general population (16% incestuous abuse before age 16, 34% sexual abuse before age 16: Draijer, 1988, 1990), they are very similar to those found among Dutch female psychiatric inpatients (44%: Nicolai, 1990; 45%: Draijer, unpublished data). No victimization rates were available for Dutch treatment-seeking male alcoholics.

Some important findings emerged from the studies among adult treated alcoholics. First, prevalence rates of abuse histories in adult males, who constitute the majority of treatment-seeking alcoholics, were lacking. Secondly, the observed victimization rates varied widely from study to study. Concerning this latter issue, it is acknowledged that, apart from differences in the definitions of abuse, variation in the elicitation technique (e.g. spontaneous disclosure, chart review, direct questioning) of abuse histories strongly affects reported abuse rates (e.g. Jacobson et al., 1987; Rohsenow et al., 1988; Draijer, 1990). Among adult clients in substance abuse treatment, for instance, prior to routinely asking about histories of childhood sexual abuse, 4% of males and 20% of females reported such experiences
(Rohsenow et al., 1988). After the clients were asked systematically about such sexual abuse histories, the rate for men quadrupled (16%) and the rate for women increased to 75%. In addition, variation in the ways of systematic questioning also affects abuse rates, with measures using more general terms (e.g. “Were you ever sexually abused?”) yielding less reports of abuse than methods using terms describing specific behaviors (e.g. “Have you ever been pressured or forced to touch someone in a sexual way?”) (see Gelles & Straus, 1988 and Draijer, 1990). Thus, for the interpretation of observed prevalence rates of physical and sexual assault experiences in any sample, evaluation of assessment methods is of paramount importance.

1.1.5 Childhood physical and sexual abuse and alcohol use disorders

Is violent victimization in childhood associated with the development of alcohol problems in adult life? Although prior research consistently suggested that childhood physical and sexual abuse histories were prevalent in alcoholics (mainly women) seeking treatment, these findings do not automatically imply an association between the two conditions. However, four of the studies with control groups showed that women in treatment for alcohol-related problems reported significantly higher rates of childhood sexual or physical abuse than did nonalcoholic controls (Covington, 1986; Downs et al., 1987; Miller et al., 1987, 1993). In addition, the literature suggested that alcohol use disorders preceded by childhood trauma history were more treatment-resistant (Root, 1989; Bollerud, 1990), and that trauma-related distress increases the vulnerability to relapse (Kovach, 1986; Young, 1990). Besides, findings from mental health client samples (Briere & Runtz, 1988; Swett et al., 1991) and general population samples (e.g. Peters, 1988; Draijer, 1990; Wilsnack, 1991) supported those found among treatment-seeking alcoholics, showing that sexually and/or physically abused women reported higher rates of alcohol problems than nonabused women. Concerning men, there seemed to be little information available regarding a relation between childhood physical and sexual abuse and adult alcohol problems.

Study findings in female samples have led to the speculation that childhood physical and sexual abuse might be etiological risk factors for the development of alcohol problems as well as risk factors for poor treatment outcomes among alcoholics. However, a major methodological issue complicates the interpretation of reported associations, namely
confounding aspects of the family environment. Although an increased risk for serious negative outcomes has been reported for individuals with a history of childhood physical or sexual abuse, the question remains whether these risks are directly attributable to childhood abuse histories rather than to other factors that predispose individuals to develop psychiatric disorders and that are associated with childhood physical and sexual abuse, such as childhood neglect, parental alcoholism or family dysfunction (Browne & Finkelhor, 1986; Wyatt & Powell, 1988; Draijer, 1990; Beitchman et al., 1992; Malinosky-Rummel & Hansen, 1993). Both the adult alcohol problems and the child abuse could originate in, for example, a family history of alcohol problems. There are several references in the clinical literature to the relationship between familial alcoholism and incestuous victimization (e.g. Barnard, 1983; Liles & Childs, 1986; Schaap, 1988). Parental alcohol problems are known to increase the risk of alcohol problems in their children (e.g. Goodwin et al., 1973; Reich et al., 1988) and it may also be associated with childhood physical and/or sexual abuse (e.g. Black et al., 1986; Carson et al., 1988; Famularo et al., 1992). However, a rather comprehensive review of the available empirical evidence of a relationship between childhood physical and sexual abuse and later alcohol problems in a diversity of samples, taking into account the efforts made to disentangle direct childhood abuse effects from family background risk factors, was lacking at the start of the present study.

In addition to a lack of information concerning the role of other family environment factors in the association between childhood abuse and alcohol problems, research evaluating whether the severity of alcohol problems in treated alcoholics is related to such childhood histories was very limited. In 1993, these data were only available for male veteran alcoholics reporting childhood physical abuse (Kroll et al., 1985; Schaefer et al., 1988). In these two studies, alcohol dependence severity was not associated with childhood physical abuse. In addition, no data were available on the effect of differences in severity of childhood abuse histories. However, trauma severity is generally acknowledged as an important factor in the trauma response. Besides, studies including a range of environmental risk factors (i.e. trauma and neglect), rather than focusing on only one type of childhood abuse, did not exist. The same applied to a possible role of trauma-related distress, such as PTSD in alcohol dependence severity in non-veteran treatment populations. Because the severity of alcohol problems is associated with poorer outcomes of alcoholism treatment, elucidating whether
trauma or neglect histories or trauma-related distress influence alcohol problem severity in treated alcoholics is clinically relevant.

1.1.6 Associations between childhood physical and sexual abuse and psychiatric comorbidity in treatment-seeking alcoholics

Based on the assumption that alcohol use disorders and comorbid psychiatric disorders may share common risk factors that increase the risk for both conditions, examining associations between childhood abuse reports and psychiatric disorders in treated alcoholics is very relevant. For practical reasons, the focus in this thesis is on Axis I comorbidity in treated alcoholics. In line with the spectrum of psychiatric syndromes associated with childhood physical and/or sexual abuse, the following symptoms are thought to be important: anxiety, depression, posttraumatic stress, dissociation and suicidal behavior.

In 1993, the relationship between childhood physical and sexual abuse and psychiatric disorders had been clearly understudied among alcoholics in treatment. Trauma histories and trauma-related distress, such as posttraumatic stress and dissociation, were generally not assessed in studies on the prevalence of psychiatric comorbidity in treated alcoholics. Concerning dissociation, this may be due to the rather recent scientific interest in dissociative disorders as an independent category implying that standard mental health measures generally do not include dissociative symptoms (Nakdimen, 1989). At the start of the current study, there was only one paper on dissociative symptoms in an alcohol inpatient veteran treatment population (mainly men), estimating a prevalence rate of 2% of Multiple Personality Disorder, nowadays referred to as Dissociative Identity Disorder (Hutzell & Eggert, 1990). Information on childhood trauma histories was not included in this study. Relevant are, furthermore, two studies restricted to male alcoholic inpatients in Veteran Administration hospitals, indicating higher rates of psychiatric distress assessed with symptom checklists associated with childhood physical abuse (Kroll et al., 1985; Schaefer et al., 1988) as well as more frequent serious suicide attempts among abused males (Kroll et al., 1985). In another study among female alcoholics attending meetings of Alcoholics Anonymous incestuous abuse histories were related to symptoms of anxiety and posttraumatic stress (Kovach, 1986). Based on these early studies, it was concluded that even if childhood abuse was measured, it concerned only one type of abuse, and that the focus had
been on psychiatric symptoms rather than disorders. Clearly, to contribute to research on long-term effects of childhood abuse on adult mental health outcomes, evaluating whether childhood physical and sexual abuse experiences are associated with a more complex clinical picture in terms of more comorbid Axis I disorders and more suicidal behavior among treated alcoholics was needed. Besides, an important, yet unanswered, question was whether childhood abuse contributes to psychiatric comorbidity rates in treated alcoholics above and beyond the effects of other negative conditions such as for instance, early parental loss, parental alcohol problems, and adult victimization experiences.

1.2 Aims and outline of the thesis

The research described in this thesis was part of the study program of the Amsterdam Institute for Addiction Research (AIAR) conducted in the Jellinek Center in Amsterdam\(^1\). The larger study focused on psychiatric comorbidity and treatment outcome among alcoholics and gamblers (see Verheul, 1997). The present study focuses on the relevance of childhood trauma, in particular sexual and physical victimization, for understanding the clinical impairment in alcoholics who were admitted to inpatient or outpatient alcohol treatment programs.

The aims of this study are to examine: (1) the prevalence of sexual and physical victimization experiences in treated alcoholics; (2) the associations of childhood sexual and physical abuse and alcoholism in adult populations, and the associations of childhood trauma with the severity of the drinking problems in treated alcoholics; and (3) the significance of childhood trauma for psychiatric comorbidity in treated alcoholics. The results of the study will be presented in the following six chapters, each of the respective chapters describing in more detail the existing knowledge at the time that the particular paper was written, the research methodology and specific research questions of the particular part of the study\(^2\).

Part II of this thesis addresses the prevalence of lifetime sexual and physical abuse among a group of treated alcoholics. The focus of the two papers presented in this section is on

\(^1\) Supported with funding by a grant from the Dutch Ministry of Welfare, Public Health & Cultural Affairs and the Ministry of Education & Science within the framework of the Health Research Incentive Program.

\(^2\) In the original publications different styles were used to present references and statistics. However, for the reader's convenience, a uniform style has been used in presenting references and statistics throughout this thesis. This does not have any consequences for the information contained in these references and statistics.
assessment issues regarding the identification of individuals with histories of physical and sexual assault. In the present study three different assessment methods were used in order to evaluate the possible influence of different methods on observed prevalence rates. More particularly, the psychometric properties of the assault items included in the European version of the Addiction Severity Index (EuropASI) are evaluated. Reported prevalence rates of physical and sexual assault in response to the standard intake questions in this clinical instrument are compared with those obtained with two other trauma measures. In Chapter 2 the sensitivity and specificity of the EuropASI assault items are evaluated using the assault questions included in a measure of exposure to traumatic events used in a diagnostic interview as standard of comparison. Chapter 3 describes the examination of the validity of the ASI regarding the identification of physical and sexual assault histories using a structured interview specifically designed to assess childhood and adult assault experiences as an external criterion.

Part III focuses on associations between childhood trauma, trauma-related distress and (the severity of) alcohol use disorders. In the first place, attention is paid to the question whether childhood abuse contributes to the risk of initiating or developing alcohol problems. Secondly, the focus is on the question whether childhood abuse affects the severity of the drinking problems once alcohol use disorders have developed. Chapter 4 involves a review of the empirical literature published before the second half of 1997, focusing on associations between both childhood sexual and physical abuse and the development of later alcohol problems in a diversity of study populations. Information concerning the role of other childhood factors in the association between childhood abuse and alcohol problems is evaluated as well. Since reviews outdate themselves quickly, an update of the major empirical findings in this area over the past five years is included in Chapter 8 of this thesis, the general discussion. Chapter 5 describes the results of a cross-sectional study among 155 treated alcoholics, investigating associations between (childhood) trauma, trauma-related distress and the severity of drinking problems.

Part IV deals with associations between childhood trauma, particularly sexual and physical abuse, and psychiatric comorbidity in the same 155 treatment-seeking alcoholics, focusing on Axis I comorbidity. Chapter 6 reports on psychiatric comorbidity specifically associated with
childhood abuse. The clinical syndromes included were: affective and anxiety disorders (including PTSD). Suicidal behavior was assessed as well. Multivariate statistical techniques were used to examine the independent effects of childhood physical and sexual abuse on the presence or absence of comorbid psychopathology, accounting for the effects of other childhood adversities and adult victimization experiences. Chapter 7 focuses on dissociation in treated alcoholics. Since the start of the current study, several papers have been published regarding associations between childhood abuse experiences and dissociative symptoms in substance abusers. Guided by the outcomes of these studies, the initial question whether there is a relation between childhood trauma and dissociative symptoms in treated alcoholics shifted into the question if this relationship can be studied at all in this specific population. The paper attempts to resolve inconsistencies reported in previous studies regarding a trauma-dissociation relation by empirically testing three hypotheses regarding the absence of a trauma-dissociation link in treatment-seeking alcoholics.

Finally, Part V includes the general discussion section of this thesis. In the final chapter, Chapter 8, the main findings will be discussed in the context of the recent developments in the scientific study of the comorbidities of traumatic exposure, alcohol use disorders, and concurrent psychiatric disorders. Furthermore, methodological issues that are important for the interpretation and extrapolation of results will be addressed. Suggestions for future research and possible implications of the results will be given.