

Characteristics of substance dependence in adolescents with and without a history of trauma

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Background

Numerous studies have documented a strong correlation between trauma exposure and substance abuse in young people. The link between trauma and substance abuse is even more striking among adolescents with posttraumatic stress disorder (PTSD).

Aim of the study

The aim of this study was to address the characteristics of substance dependence and comorbid psychiatric disorders in adolescents with and without a history of trauma (physical or sexual) and in a subgroup that had posttraumatic stress disorder.

Methodology

A total of 78 adolescents aged between 12 and 17 years who attended the drug dependence clinic at the Neuropsychiatry center, Tanta University, were classified according to the Childhood Trauma Questionnaire into 29 without a history of trauma, 15 with PTSD, and 34 with a history of trauma without PTSD. All groups were assessed as regards onset of drug use, number of substances used, motives for use, attempts for abstinence, and comorbid psychiatric disorders using The MINI International Neuropsychiatric Interview.

Results

It was found that adolescents exposed to trauma had early onset of drug abuse and were more likely to use tramadol, followed by cannabis and benzodiazepines. They have a tendency to polysubstance abuse compared with others. The primary reasons for drug abuse in trauma patients were coping with stress and enhancement of self-esteem, whereas it was social pressure in others and they made less attempts at abstinence. Anxiety disorders and psychotic disorders were more common in the PTSD group.

Conclusion

Adolescent substance abuse is common among children with sexual or physical trauma and needs careful attention to minimize comorbid psychiatric disorders.

Keywords:

adolescents, physical and sexual trauma, substance dependence, posttraumatic stress disorder

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Introduction

Numerous studies have documented a strong correlation between trauma exposure and substance abuse in young people. A recent survey of adolescents revealed that teens who had experienced physical or sexual abuse/assault were three times more likely to report past or current substance abuse than those without a history of trauma [1]. Surveys of adolescents receiving treatment for substance abuse have shown that more than 70% had a history of trauma exposure [2,3]. The link between trauma and substance abuse is even more striking among adolescents with posttraumatic stress disorder (PTSD). Studies indicated that up to 59% of young people with PTSD subsequently develop problems related to substance abuse [3–6].

Many researchers and providers point to the self-medication hypothesis to explain the connection between

trauma exposure and substance abuse, suggesting that youth resort to psychoactive drugs and alcohol in an attempt to cope with traumatic stress or reminders of loss. Although there is a lot of evidence to support this pathway, studies evaluating the frequency of substance abuse after trauma exposure have reported rates as high as 76% [6–9]. It is also true that substance abuse can increase an adolescent's risk of trauma exposure and of experiencing traumatic stress symptoms.

Successful treatment of adolescents with co-occurring traumatic stress and substance abuse therefore requires interventions that address the challenges of both disorders. Failure to provide such comprehensive treatments may significantly impair these teenagers' likelihood of long-term recovery. In the absence of coping strategies to manage distress associated with trauma, adolescents with co-occurring disorders are more likely to relapse and revert to maladaptive coping strategies than are teenagers

with substance abuse alone [10]. There are very few studies in Egypt that have investigated the characteristics of substance dependence in adolescents with a history of trauma [11]. The aim of this study was to address the characteristics of substance dependence and comorbid psychiatric disorders in adolescents with and without a history of trauma (physical or sexual) and in a subgroup that had PTSD.

Methodology

The study included all adolescent substance dependants whose ages ranged between 12 and 17 years and who were being treated at the Drug dependence Outpatient Clinic of Psychiatry, Neurology and Neurosurgery Center, Tanta University, from October 2009 to November 2010. They were diagnosed according to *Diagnostic and Statistical Manual of Mental Disorders* Fourth Edition [12] diagnostic criteria for drug dependence and administered a Childhood Trauma Questionnaire (CTQ). The Childhood Trauma Questionnaire is a 28-item self-report retrospective inventory that measures childhood or adolescent abuse and neglect. It is straightforward and easy to use. The CTQ can be administered individually or to a group. The examinee responds to 28 simple questions on a 5-point scale ranging from Never True to Very Often True. The central constructs underlying the questionnaire are emotional, physical neglect and abuse, and sexual abuse. Other traumatic events that may occur during childhood, such as the death of a parent or a major illness, are not assessed. The items are written at a sixth grade reading level, and reading level and intellectual functioning should be assessed before administering the scale (by Wechsler Adult Intelligence Test by Mleka 2000) [13,14]. The measure also includes a three-item Minimization/Denial scale indicating the potential underreporting of maltreatment. Participants respond to each item in the context of 'when you were growing up' and answer according to a 5-point Likert scale ranging from 'never' = 1 to 'very often' = 5, producing scores of 5–25 for each trauma subscale. The three items comprising the Minimization/Denial scale are dichotomized ('never' = 0, all other responses = 1) and summed; a total of one [1] or greater suggests the possible underreporting of maltreatment (false negatives). Participants were divided into three groups: group I comprised adolescents with substance dependence without a history of trauma; group II comprised adolescents with a history of trauma with PTSD (current or past); and group III comprised adolescents with a history of trauma without posttraumatic stress disorder. All participants were assessed with regard to onset of drug use, number of substances used, motives for use, attempts at abstinence, and comorbid psychiatric disorders using The MINI International Neuropsychiatric Interview. This interview was translated and validated into Arabic by Ghanem *et al.* [15,16]. Written consent was taken from all patients and controls after they were informed of all the steps and aims of the study.

Statistical analysis

The collected data were organized and statistically analyzed using the 15 Minitab software [17] statistical computer package. Mean and standard deviations were used for presentations of quantitative data. The differences with regard to psychiatric disorders were analyzed using a multivariate analysis of variance. The Student *t*-test was used for comparison between two means. The χ^2 test and the Fischer exact test were used for comparison between the studied groups. A 5% level of significance was adopted for interpretations of tests of significance.

Results

During the study period, 78 adolescents with substance dependence whose ages ranged between 12 and 17 years were interviewed. Of them, 29 (37%) reported no trauma (physical or sexual) during childhood and were termed group I; 49 (63%) reported trauma (physical, sexual, or both) and were further divided into group II (15 patients, 19%; those who developed PTSD) and group III (34 patients, 44%; those without PTSD). There was no significant statistical difference among the studied groups as regards age or sex ($P > 0.05$), although there were more female patients in trauma groups II and III (33; 32%) than in group I (18%). Early onset of substance dependence was significantly more in groups II and III than in group I, but there was no significant difference between groups II and III. The CTQ showed significantly higher scores in the physical trauma subscale in patients with PTSD ($P < 0.05$), but no significant differences were found between the two groups on the sexual trauma subscale ($P > 0.05$) (Table 1).

Characteristics of substance used in the studied groups

It was found that all patients had a tendency to polysubstance abuse. In group I, 41% used more than two drugs in comparison with 53% in group II and 50% in group III. The difference was not statistically significant ($P > 0.05$). In addition, 44% in group I, 40% in group II, and 41% in group III used two drugs. Only a minority used only one drug in the three groups (15% in group I, 7% in group II, and 9% in group III). The difference was not significant ($P > 0.05$) (Table 2).

Tramadol was the most commonly used drug by groups II and III (93 and 94%, respectively), followed by cannabis (93 and 79%, respectively), opiates (60 and 47%, respectively), and benzodiazepines (13 and 20%, respectively). Cannabis was the most commonly used drug by group I (82%), followed by Tramadol (65%), opiates (41%), and benzodiazepines (17%). Other substances include anticholinergics, inhalants, and barbiturates and were used by 37% of group I, 33% of group II, and 44% of group III. The difference was not statistically significant ($P > 0.05$) (Table 2). Nicotine was excluded as it was used by all patients.

Social pressure was the most important motive for substance use in group I (44%), which was statistically significant compared with groups II and III (7 and 6%,

Table 1 Demographic data of the patients

Variable	Group I patients without trauma <i>N</i> =29	Group II patients with trauma (with PTSD) <i>N</i> =15	Group III traumatic patients (without PTSD) <i>N</i> =34	
Age:(Years)				
Range	12–17	12–17	12–17	<i>F</i> =0.17
Mean	14.51	14.20	14.38	<i>P</i> =0.846
SD ±	1.76	1.74	1.70	
Sex				
Males	24 (82%)	10 (67%)	23 (68%)	<i>X</i> ² =2.204
Females	5 (18%)	5 (33%)	11 (32%)	<i>P</i> =0.332
Duration of substance use: (months)				<i>F</i> =8.74
Range	12–48	12–60	12–59	<i>P</i> =0.00 ^a
Mean	25.03	38.80	37.32	<i>T</i> ₁ = −3.12
SD ±	11.32	15.02	13.53	<i>P</i> =0.005 ^a
CTQ physical scores:				<i>T</i> ₂ = −3.93
Range		10–17	6–14	<i>P</i> =0.000 ^a
Mean		12.67	9.79	<i>P</i> =0.000 ^a
SD ±		2.16	1.93	<i>T</i> ₃ = 0.33
CTQ sexual scores:				<i>P</i> =0.747
Range		5–16	5–18	<i>T</i> = 4.43
Mean		9.93	11.35	<i>P</i> =0.140
SD ±		2.89	3.29	

CTQ, Childhood Trauma Questionnaire; PTSD, posttraumatic stress disorder; SD, standard deviation.

^aSignificant *T*₁ (Group I vs. II). *T*₂ (Group I vs. III). *T*₃ (Group II vs. III).**Table 2 Characteristics of drug dependence in the studied patients**

Variable	Group I patients without trauma <i>N</i> =29	Group II patients with trauma (with PTSD) <i>N</i> =15	Group III traumatic patients (without PTSD) <i>N</i> =34	
Number of drug used				
More than two	12 (41%)	8 (53%)	17 (50%)	<i>P</i> =0.900
Only two	13 (44%)	6 (40%)	14 (41%)	
Only one drug	4 (15%)	1 (7%)	3 (9%)	
Type of drug				
Tramadol	19 (65%)	14 (93%)	32 (94%)	<i>P</i> =0.005 ^a
Cannabis	24 (82%)	14 (93%)	27 (79%)	<i>P</i> =0.481
Opiates	12 (41%)	9 (60%)	16 (47%)	<i>P</i> =0.502
Benzodiazepines	5 (17%)	2 (13%)	7 (20%)	<i>P</i> =0.824
Others	11 (37%)	5 (33%)	15 (44%)	<i>P</i> =0.752
Motives for use				
Social pressure	13 (44%)	1 (7%)	2 (6%)	<i>P</i> =0.000 ^a
Curiosity	8 (28%)	3 (20%)	4 (11%)	<i>P</i> =0.282
Enhancement of self-esteem	2 (7%)	8 (53%)	10 (30%)	<i>P</i> =0.003 ^a
Coping with stress	1 (3%)	14 (93%)	27 (79%)	<i>P</i> =0.000 ^a
Others	5 (18%)	2 (13%)	4 (11%)	<i>P</i> =0.820
Attempts at abstinence				
Yes	12 (41%)	3 (20%)	5 (14%)	<i>P</i> =0.046 ^a
No	17 (95%)	12 (80%)	29 (86%)	
Comorbid psychiatric disorders				
Depressive disorders	8 (28%)	7 (47%)	15 (44%)	<i>P</i> =0.311
Anxiety disorders (other than PTSD)	6 (20%)	10 (67%)	14 (41%)	<i>P</i> =0.011 ^a
Psychotic disorders	2 (7%)	1 (7%)	3 (9%)	<i>P</i> =0.947

PTSD, posttraumatic stress disorder.

^aSignificant <0.05 calculated by Fischer's exact test.

respectively). Curiosity also was the motive for 28% in group I, which was not significant in relation to 20 and 11% in groups II and III, respectively. In contrast, coping with stress was the most important motive for substance use in patients with PTSD (93%) and in trauma patients without PTSD (79%), followed by enhancement of self-esteem (53% in group II and 30% in group III). The difference between both groups of trauma patients was statistically significant ($P<0.05$) (Table 2).

Patients without trauma (group I) showed more significant attempts at abstinence than those who had undergone trauma ($P<0.05$) (Table 2).

Anxiety disorders (other than PTSD) comprised the most common comorbidity among group II (67%) patients in comparison with group III (41%) and group I (20%) ($P<0.05$). Psychotic disorders as comorbid disorders were found in a small percentage in the three groups

(7, 7, and 9%, respectively) but were definitely more but not significant in the PTSD group ($P > 0.05$). No significant difference was found among the three groups as regards depressive disorders ($P > 0.05$).

Discussion

Much research has been devoted in identifying the common risks and protective factors associated with adolescent substance use. In general, teenagers are less likely to succumb to external pressure toward drug use if they have a strong sense of attachment to parents who clearly communicate their disapproval of substance use and antisocial behaviors [18–20] and who have a strong commitment to doing well in school. Conversely, associating with substance-abusing peers and limited availability of educational and recreational opportunities are associated with increased risk of substance abuse [21,22]. In this study, we tried to identify the difference between those who were exposed to trauma and other adolescents without exposure to trauma.

We found that there were more male patients than female patients in both groups with no difference between them. Sex is an important factor in the use and effects of alcohol and other drugs of abuse. Our explanation is that boys tend to have opportunities for use earlier in life and thus tend to start at younger ages [23]. However, once girls have the opportunity to experiment, they are just as likely as boys to use drugs of abuse [24]. Rates of drug use for both sexes have been converging over the past decade. Research indicates that there are few differences in the type or amount of substances that male and female adolescents use; however, the effects of substances on their emotional and physiological health can vary. Others have indicated that substance abuse stemming from traumatic events and/or psychological problems is more common in female patients than in male patients. In addition, female substance abusers are more vulnerable to some of the physiological effects and psychological difficulties that can result from substance use [25].

In this study, it was found that onset of drug abuse is earlier in patients with trauma than in patients without trauma. Trauma has been shown to adversely affect many of the neurobiological systems responsible for cognitive development and regulation of emotions and behavior. In adolescents, this can manifest in delays in the developmental processes that would normally enable them to effectively evaluate the consequences of their behavior, to make realistic appraisals for danger and safety, to moderate daily behavior to meet long-term goals, and to make increased use of abstract thinking for academic learning and problem solving. Harley *et al.* [26] found that childhood trauma leads to very early cannabis use, which agrees with our results. Trauma at an early age leads to emotional and cognitive disturbances that may enhance early substance use in such adolescents.

Although the traumatic group seems to be polysubstance abusers compared with the nontraumatic group, the difference was not significant in this study. Patients with

a history of trauma may use more than one substance to self-medicate themselves and achieve homeostasis [27]. In addition, they were found to use tramadol and cannabis as the main substances. Harley *et al.* [26] found a close association of childhood trauma with early cannabis use, and they found that such clear association may help the appearance of psychosis in such patients. Johnson *et al.* [28] reported that early onset of marijuana and heroin use, alcohol dependence, and opiate dependence was associated with exposure to a traumatic event for male substance abusers, and early onset of alcohol use and alcohol dependence was associated with exposure to a traumatic event for female substance users. Tramadol is one of the analgesics that is abused heavily in Egypt and many adolescents use it because of its easy availability and low cost. The abuse of prescription painkillers has risen markedly. According to emergency department data USA, in 2005 nearly 50 000 youth between the ages of 12 and 17 years presented to the emergency department because of nonmedical uses of prescription painkillers. An estimated 14% of high school seniors have used prescription drugs for nonmedical reasons at least once in their lifetime, making prescription drugs the second most commonly abused illegal substance by teenagers, after marijuana [29].

On studying the motives for drug abuse in both groups in this study, patients with a history of trauma abuse substances as a method of coping with stress and for enhancement of self-esteem, whereas others abuse drugs under social pressure. Understanding the reasons why youth start using drugs or alcohol – as well as their reasons for continuing or discontinuing use – is crucial to developing effective substance abuse interventions. Similar results found in a recent 30-month study of 923 teenagers receiving outpatient and residential substance abuse treatment have provided some insight into the motivations behind adolescents' substance abuse and eventual recovery [30]. In this study, three quarters of the teenagers cited social pressure and experimentation as their reasons for initiating drug or alcohol use. Teenagers may start using drugs or alcohol because they see 'every one else' doing it and want to blend in, because it is a way of spending time with friends, of being accepted, of becoming popular, of enhancing social and other activities, or because they fear that if they refuse they might alienate potential friends. Many adolescents reported that curiosity led to first use, whereas others reported that they decided to start after witnessing use by a parent or relative. Of note, only 7% reported initiating use to 'cope with difficulties' [30].

Many researchers and providers point to the self-medication hypothesis to explain the connection between trauma exposure and substance abuse, suggesting that youth turn to psychoactive drugs and alcohol in an attempt to cope with traumatic stress or reminders of loss.

In our study, traumatic patients with and without PTSD had less tendency for abstinence. It is likely that, for teenagers experiencing traumatic stress, continued substance use may serve as a coping strategy to deal with

stress, forget unpleasant experiences, avoid negative emotions, do away with worries, or feel numb or indifferent to the challenges of daily life or of reminders of past trauma [31].

Comorbid psychiatric disorders were investigated in this study. Anxiety disorders were found to be common associations in traumatic groups, whereas depression was the most common in the nontraumatic group. Patients with PTSD are more prone to psychosis. Epidemiological studies have consistently reported a high rate of comorbid mental health problems among adolescents with substance use disorders [32]. In all, 32% of adolescents with current substance abuse had co-occurring mood disorders [33]. Increased suicide attempts were also found in adolescents with co-occurring substance use disorders and mood disorders [34]. Anxiety disorders, especially panic and social phobia, are common in adolescent substance abusers associated with a history of trauma [35]. Adolescents with PTSD are very common and have higher comorbid mental health and used more drugs in their life time [36]. A high prevalence of cannabis use among those patients explains the established psychotic disorders observed [36].

Limitation of the study

The Questionnaire for trauma, although commonly used in many cultures, was not standardized to the Egyptian culture.

Conclusion

Early physical or sexual trauma has considerable impact on adolescents' drug dependence and needs careful investigation to address their coping abilities and evaluate effective strategies for their treatment.

Acknowledgements

Conflicts of interest

There is no conflict of interest to declare.

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خصائص تعاطي المخدرات في المراهقين الذين تعرضوا للإيذاء والذين لم يتعرضوا

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كثير من الدراسات وجدت علاقة وثيقة بين التعرض للإيذاء الجسدي أو الجنسي وإدمان المخدرات عند المراهقين والعلاقة تكون أكثر متانة مع هؤلاء المصابون باضطراب القلق النفسي ما بعد حادثة.

الغرض من الدراسة: هو دراسة الخصائص المميزة للمراهقين الذين يدمنون المخدرات والاضطرابات النفسية المصاحبة في المراهقين المصابين وغير المصابين بالإيذاء الجسدي أو الجنسي في الصغر هؤلاء المصابون بالقلق النفسي ما بعد حادثة.

طريقة الدراسة: 78 من المراهقين تتراوح أعمارهم بين 12 و17 عاما من هؤلاء الذين تردوا علي عيادة الإدمان في مركز الطب النفسي وأمراض المخ والأعصاب-جامعة طنطا. تم تقسيمهم الي 29 ليس لديهم تاريخ لإيذاء من قبل و15 مصابون باضطراب القلق ما بعد حادثة و34 لهم تاريخ مرضي بالإيذاء فقط. كل المرضى تمت دراستهم من حيث بداية استعمال المخدرات وعدد المواد المستخدمة وأسباب تعاطي المخدر ومحاولة الإقلاع عن الإدمان والاضطرابات النفسية المصاحبة.

النتائج: لقد وجد أن المراهقين الذين تعرضوا للإيذاء في صغرهم تعاطوا المخدرات مبكرا وعادة ما يستعملون الترامادول والقنب الهندي يليهم المهدئات الصغرى كما أن لديهم الدافع لاستخدام عدد كبير من المواد المخدرة والدافع لديهم هو التعامل مع الضغط النفسي والمحافظة علي الذات في حين أن مجموعة المراهقين الذين لم يتم إيذائهم فانهم يستخدمون المخدر تحت الضغط الاجتماعي. وكانت مجموعة المراهقين الذين تم إيذائهم لديهم مقاومة للإقلاع أكثر. وقد وجد أن اضطراب القلق والذهان أكثر في المجموعة المصاحبة باضطراب القلق ما بعد حادثة.

الخلاصة: إدمان المراهقين للمخدرات أكثر في الأطفال الذين تم إيذائهم جسديا أو جنسيا ويحتاجون للرعاية حتي تقل الاضطرابات النفسية المصاحبة.