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Effect of Childhood Trauma on Substance Users' Attitudes of Coping with Stress

Madde Kullanıcılarının Stresle Başa Çıkma Tutumlarında Çocukluk Travmalarının Etkisi

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Abstract

Objective: This study seeks to examine the effects of childhood traumas on substance users' attitudes of coping with stress.
Method: This descriptive study seeking relationship was conducted with 133 individuals diagnosed with substance use and receiving treatment in the alcohol and substance treatment centre and closed psychiatry clinics of a mental health hospital located in Turkey.
Results: The mean age of first substance use of the participants included in the study was 17.8 ± 4.7. The participants got the highest score from the emotional neglect subscale of the Childhood Trauma Questionnaire (12.83 ± 3.46). Individuals in the study got the highest score from the religious coping subscale of the Coping Orientation to Problems Experienced Inventory (13.39 ± 2.71). Childhood traumatic experiences were found to be effective in the development of coping attitudes including denial, behavioural disengagement, use of emotional social support, substance use, and acceptance.
Conclusion: Childhood traumatic experiences of substance users have an effect on their dysfunctional coping attitudes. It is recommended that psychiatric nurses include primary, secondary, and tertiary protective approaches towards childhood traumas in their work on combating addiction.

Keywords: Social media addiction, attachment styles, contingencies of self- worth

Öz

Amaç: Bu çalışma, çocukluk çağı travmalarının madde kullanıcılarının stresle başa çıkma tutumları üzerindeki etkilerini incelemeyi amaçlamaktadır.
Yöntem: İlişki arayan tanımlayıcı tipteki bu araştırma, Türkiye'de bulunan bir ruh sağlığı hastanesinin alkol ve madde tedavi merkezi ve kapalı psikiyatri kliniklerinde madde kullanımı tanısı alan ve tedavi gören 133 kişi ile yürütülmüştür.
Bulgular: Araştırmaya dahil edilen katılımcıların ilk madde kullanım yaş ortalamasının 17.8 ± 4.7 olduğu belirlenmiştir. Katılımcıların Çocukluk Dönemi Örselenme Yaşantıları Ölçeği'nden en yüksek puanı duygusal ihmal alt ölçeğinden aldığı saptanmıştır (12.83 ± 3.46). Araştırmadaki bireylerin Başa Çıkma Tutumları Değerlendirme Ölçeği'nin dini başa alt ölçeğinden en yüksek puanı aldıkları belirlenmiştir (13.39 ± 2.71). Çocukluk çağı travmatik yaşantılarının inkar, davranışsal olarak geri çekilme, duygusal sosyal destek kullanımı, madde kullanımı ve kabullenme gibi başa çıkma tutumlarının gelişiminde etkili olduğu bulundu.
Sonuç: Madde kullanıcılarının çocukluk çağı travmatik yaşantıları, onların işlevsel olmayan başa çıkma tutumları üzerinde etkilidir. Psikiyatri hemşirelerinin bağımlılıkla mücadele çalışmalarında çocukluk çağı travmalarına yönelik birincil, ikincil ve üçüncül koruyucu yaklaşımlara yer vermeleri önerilmektedir.

Anahtar kelimeler: Madde kullanımı, çocukluk çağı travması, stresle başa çıkma, hemşirelik

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Introduction

Although substance use and related disorders date back to ancient times, they are regarded as critical health problems all over the world due to their increasing incidence in recent years and users tend to use substances at earlies ages (1). The relevant problem not only impairs the social functionality of substance users but also causes an increase in death and crime rates (2). The increase in substance use-related disorders has led to an increase in research done to reveal the causes and consequences of the problem (3, 4).

It is crucial to identify the attitudes of substance users in coping with stress as well as to examine the factors behind them. Coping with stress is defined as a dynamic process in which individuals can change their emotional, physical, cognitive, and behavioural efforts in accordance with their demands in the face of a stressful experience (5). Some studies reveal that individuals with substance use disorder fail to cope with psychosocial problems and therefore fail to use functional coping methods (6-8). On the other hand, substance use is considered an inappropriate coping attitude towards stressful life events (8, 9).

A myriad of studies have proven that traumatic experiences in early childhood or adolescence play a crucial role in the aetiology of substance use (10, 11). At the beginning of these traumatic experiences are childhood neglect and abuse experiences. Any approach that causes actual or potential harm to children's development is considered neglect or abuse (12-16). Studies in the literature on this subject generally focus on physical, sexual, emotional abuse and neglect (17). Traumatic stress experienced during childhood can result in changes in the emotional and behavioural responses of individuals as well as in the development of the brain regions responsible for regulating impulsivity, decision-making, and reward behaviors (18). Accordingly, individuals use substances to mitigate the negative effects and stress associated with childhood trauma and may resort to inappropriate ways of coping (19).

The literature review reveals the importance of studies on the coping strategies of stress and childhood traumatic experiences of substance users (20, 21). This study, on the other hand, seeks to determine the effect of childhood traumatic experiences on substance users' styles in coping with stress. This research also reveals childhood traumas that affect substance users most, the coping styles they use most, and the effects of traumas on their coping attitudes. The findings obtained from the research are expected to help professionals working with substance users recognize the needs underlying the behaviors and provide psychosocial care for this.

In the study, the following questions were addressed: "What are the childhood trauma levels of substance users?", "What coping styles do substance users use most?", "Do substance users' childhood traumas affect their coping styles?". As hypothesis, the effect of childhood traumatic experiences on the stress coping styles of individuals with substance use were examined. .

Method

This descriptive study seeking relationship was conducted with 133 individuals diagnosed with substance use and hospitalized in a Mental Health and Disorders Hospital located in Turkey between 20 June and 20 October in 2018. An ethics committee approval (KAEK 2018/205) was obtained from the university where the study was conducted, and institutional approval (61646299-12374) was obtained from the Provincial Health Directorate to which the relevant hospital is affiliated. Attention was paid to the principle of volunteering. Patients were informed about the study. Verbal and written consent for participation was obtained.

Sample

The study was carried out in Alcohol and Substance Treatment Centers (AMATEM) and closed psychiatry clinics of a mental health hospital in Turkey's middle black sea region. Voluntary treatment is provided for

patients hospitalized with the diagnosis of alcohol, substance, and behavioural addiction in AMATEM clinics. The treatment period is 21 days and only male patients are treated in these clinics. These clinics have rules and a point system that should be followed by individuals undergoing treatment. Within the scope of treatment, activities such as pharmacological treatment, purification treatments, psychosocial adjustment trainings, group activities, sports activities, and occupational activities are provided by physicians, nurses, psychologists, and social workers. Similar activities are carried out in psychiatry clinics, but these clinics do not have a point system and patients can be hospitalized on a compulsory basis. Among the individuals treated in these clinics, patients over the and age of 18 who were diagnosed with substance use and voluntary were included in the study. Patients who did not have the mental capacity to understand and answer the questions, who had a comorbid psychotic disorder, who were aggressive, who had orientation and memory problems were not included in the study (7 individuals).

Analysis was performed in G*Power 3.1 program to determine the sample size of the study. The correlation coefficient for CTQ-SF and use of emotional social support sub-dimension was taken as r=-0.301. According to this value, the sample size was determined as 133 with 95% confidence interval, 5% margin of error, 95% power, and 0.09 effect size (22).

Procedure

Measurements of the study were made via the face-to-face interview technique. In order to perform the measurements, the individuals included in the sample were informed about the study by the researchers. After obtaining the consent of the individuals to participate in the study, the data collection process was started. After the individuals were informed about the data collection forms, they were asked to fill in these forms. The researchers informed them and performed the application. It took an average of 10-12 minutes for the participants to answer all the questions.

In the study, the "Patient Descriptive Information Form", the "Childhood Trauma Questionnaire-Short Form Translated into Turkish (CTQ-SF)" and the “Coping Orientation to Problems Experienced Inventory (COPE)" were used as data collection forms.

Measures

Patient Descriptive Information Form

This form consists of 14 questions aimed at analysing the sociodemographic characteristics and mental status of the participants related to the subject under investigation (4, 5, 8-10, 19).

Childhood Trauma Questionnaire-Short Form Translated into Turkish (CTQ-SF)

The CTQ-SF developed originally in English by Bernstein et al on 2003 is a retrospective measure for reviewing the history of abuse in childhood (23) and was adapted into Turkish by Kaya on 2014 (24). The scale contains five factors: Physical Abuse, Physical Neglect, Emotional Abuse, Emotional Neglect, and Sexual Abuse. In the study of the Turkish adaptation of the scale, the Cronbach alpha internal consistency coefficients of the factors were .81 for emotional abuse, .79 for physical abuse, .80 for sexual abuse, .81 for emotional neglect, and .38 for physical neglect (24). The lowest score that can be obtained from each factor in the CTQ-SF is 5 while the highest score is 25. A high total score indicates a high level of childhood traumatic experiences while a low total score indicates a low level of childhood traumatic experience. In this study, the Cronbach Alpha internal consistency coefficient of the scale was found to be 0.79.

Coping Orientation to Problems Experienced Inventory (COPE)

Developed by Carver et al. (1989), the COPE is a self-report inventory consisting of 60 questions (25). The Turkish validity and reliability study of the scale was performed by Ağargün et al on 2005 (26). It consists of 15 subscales, each of which consists of 4 questions. These subscales are the use of instrumental social support, refrainment, active coping, self-distraction, planning, mental disengagement, behavioural disengagement, denial, problem-focused coping, venting, substance use, positive reframing and growth,

religion, humour, acceptance, and use of emotional social support. Each of the subscales gives information about a different coping attitude. A high score indicates which coping style is used more. The Cronbach α value was measured as 0.79 and the scale was found to be reliable (26). In this study, the Cronbach's alpha internal consistency coefficient of the scale was found to be 0.84.

Statistical Analysis

The SPSS 21.00 program was used in the analysis of the data. Frequency and percentage values were used in the data on the sociodemographic characteristics of the participants. The arithmetic mean and standard deviation were calculated for the age, CTQ-SF, and COPE variables. The Kolmogorov Smirnov Test was used to determine the conformity of the data to the normal distribution. The relationship between the total score of the CTQ-SF and the sub-scales of the COPE was analysed by Pearson Correlation analysis. The effect of the CTQ-SF on COPE sub-scale scores was determined by multiple linear regression analysis. The significance level was accepted as $p< 0.05$.

Table 1. Distribution of patients' sociodemographic characteristics

Characteristics		**n**	**%**
Age (M±SD)	31.9 ± 10.5 (Min. 18.0- Max. 63.0)		
Gender	Male	125	94.0
	Female	8	6.0
Working status	Not working	23	17.3
	Working/Retired	7	5.3
	Working/Officer	8	6.0
	Working/Self-employed	38	28.6
	Working/Worker	34	25.6
	Working/Others	23	17.3
Place of residence	Province	83	62.4
	District	30	22.6
	Village	20	15.0
Marital Status	Married	55	41.4
	Single	78	58.6
Educational Background	Primary/Secondary School	73	54.9
	High School	48	36.1
	University	11	8.3
	Graduate	1	0.7
Income level	I can meet my needs	94	70.7
	I cannot meet my needs	39	29.3
Living with	Alone	16	12.0
	Family	113	85.0
	Friend	3	2.2
	Others	1	0.8
Number of children	None	65	48.9
	1	20	15.0
	2	25	18.8
	3	19	14.3
	4 and over	4	3.0
Total		133	100

M: Arithmetic mean; SD: Standard Deviation; Min: Minimum; Max: Maximum; n: Sample; %: Percent

Results

The mean age of the individuals participating in the study is 31.9 ± 10.5. 94% of the participants are male, 28.6% are self-employed, 62.4% live in the province, and 58.6% are single. Besides, 54.9% of the individuals included in the study are primary-secondary school graduates, 70.7% have an income level that is enough to meet their needs, 85% live with their families and 48.9% do not have children (Table 1).

Table 2. Distribution of patients' characteristics related to their mental state

Characteristics		**n**	**%**
Current status of substance use	I use	58	43.6
	I do not use	75	56.4
Age of first use of the substance (M±SD)	17.8 ± 4.7 (Min. 10.0-Max. 38.0)		
Concomitant diagnosis	None	111	83.5
	Anxiety disorder	5	3.8
	Bipolar disorder	7	5.3
	Depressive disorder	3	2.2
	Diabetes mellitus	4	3.0
	Cardiovascular diseases	3	2.2
Substance use in the family	None	95	71.4
	Father	23	17.3
	Mother and father	1	0.8
	Siblings	14	10.5
If a person receives psychiatric treatment in the family	Yes	19	14.3
	No	114	85.7
Total		133	100

M: Arithmetic mean; SD: Standard Deviation; Min: Minimum; Max: Maximum; n: Sample; %: Percent

Table 3. Mean scores of CTQ-SF and Cope sub-scales

Scales	**M±SD**
CTQ-SF Sub-Scales	
Physical abuse	9.40±4.67
Sexual abuse	7.48±4.58
Emotional abuse	10.36±4.65
Physical neglect	10.70±3.69
Emotional neglect	12.83±3.46
COPE- Sub-Scales	
Religious coping	13.39 ± 2.71
Positive reframing and growth	12.14 ± 2.54
Substance use	11.71 ± 4.08
Planning	11.59 ± 2.62
Active coping	11.52 ± 2.85
Problem-focused coping and venting	11.17 ± 3.18
Self-distraction	10.77 ± 2.31
Refrainment	10.74 ± 2.60
Acceptance	10.65 ± 2.77
Use of instrumental social support	10.50 ± 3.24
Use of emotional social support	10.38 ± 2.82
Mental disengagement	10.19 ± 2.69
Behavioural disengagement	8.76 ± 3.02
Denial	8.66 ± 3.01
Humour	8.02 ± 3.02

M: Arithmetic mean; SD: Standard Deviation

The mean age of the participants for first substance use was found to be 17.8 ± 4.7. 56.4% of the individuals report that they are not currently using substances. Besides, 83.5% of the participants do not have a concomitant disease, fathers of 17.3% of the participants use substances, and 14.3% of the participants have a family member who is receiving psychiatric treatment (Table 2).

Table 4. Correlations of CTQ-SF total scores and scores of cope sub-scales

CTQ-SF Total Scores		r	p
COPE Sub-Scales	Religious coping	0.128	0.141
	Positive reframing and growth	0.225	0.773
	Substance use	0.281	0.001*
	Planning	0.069	0.429
	Active coping	0.074	0.399
	Problem-focused and venting	0.109	0.210
	Self-distraction	0.131	0.133
	Refrainment	0.024	0.784
	Acceptance	0.185	0.033*
	Use of instrumental social support	0.008	0.931
	Use of emotional social support	0.171	0.049*
	Mental disengagement	0.100	0.252
	Behavioural disengagement	0.249	0.004*
	Denial	0.248	0.004*
	Humour	0.137	0.117

*p<0,05; r: Pearson Correlation

The individuals participating in the study got the highest score in emotional neglect (12.83 ± 3.46) from the mean scores of the CTQ-SF (Table 3). Other sub-scales are listed from high to low as follows: physical neglect (10.70 ± 3.69), emotional abuse (10.36 ± 4.65), physical abuse (9.40 ± 4.67), and sexual abuse (7.48 ± 4.58) (Table 3). The participants mostly scored the religious coping style (13.39 ± 2.71; Table 3) while reporting their coping attitudes in line with the mean scores of the sub-scales included in the COPE. Besides, the coping attitudes scored at the highest levels were as follows: positive reframing (12.14 ± 2.54), substance use (11.71 ± 4.08), planning (11.59 ± 2.62), active coping (11.52 ± 2.85), problem-focused coping and venting (11.17 ± 3.18) (Table 3).

Table 5. The effect of CTQ-SF sub-scales on cope sub-scales

Dependent variable (COPE Sub-scales)	R	R^2	Adjusted R^2	The Standard Error of Estimate	Durbin-Watson**	F
Denial	0.309	0.096	0.060	2.923	2.034	2.691*
Behavioural disengagement	0.328	0.108	0.073	2.914	2.092	3.064*
Use of emotional social support	0.365	0.134	0.099	2.683	2.096	3.916*
Substance use	0.375	0.141	0.107	2.625	2.238	4.164*
Acceptance	0.312	0.097	0.062	3.959	2.143	2.731*

Independent Variables (CTQ-SF Sub-scales): Physical abuse, Sexual abuse, Emotional abuse, Physical neglect, and Emotional neglect.
*p<0.05, ** Durbin-Watson statistics is one of the prerequisites of regression analysis. It is required to be between 1 and 3.

A significant correlation was found between the participants' total score on the CTQ-SF and the sub-scales of the COPE including denial (p=0.004), behavioural disengagement (p=0.004), use of emotional social support (p=0.049), substance use (p=0.001), and acceptance (p=0.033) (p<0.05; Table 4). No significant correlation was found between the CTQ and other sub-scales of the COPE (p>0.05; Table 4).

The sub-scales including denial, behavioural disengagement, use of emotional social support, substance use, and acceptance within the COPE, which were found to be associated with CTQ-SF total scores in the study, were analysed by multiple linear regression analysis. Each of the COPE sub-scales, which were found to have a significant relationship in the study, was taken as the dependent variable, while the sub-scales of

the CSQ-SF including physical abuse, sexual abuse, emotional abuse, physical neglect, and emotional neglect were taken as independent variables. Considering the models created, the independent variables explained 6.0% of the variance of the denial variable ($F=2.691$; $p<0.05$), 7.3% of the variance of behavioural disengagement variable ($F=3.064$; $p<0.05$), 9.9% of the variance of the use of emotional social support variable ($F=3.916$; $p<0.05$), 10.7% of the variance of the substance use variable ($F=4.164$; $p<0.05$), and 6.2% of the variance of the acceptance variable ($F=2.731$; $p<0.05$). The related results are given in Table 5.

Discussion

The findings obtained from this study, which was designed to highlight the effects of childhood traumas on the stress coping attitudes of individuals using substances, are discussed in this section in line with the relevant literature. In this study, the mean age of first use of the substance was determined as "17 years old", which is legally accepted as childhood in many countries, and childhood traumatic experiences were found to be at a close-to-moderate level. It is reported that negative childhood experiences are closely related to the initiation of alcohol and substance use in early and middle adolescence (11, 27). Studies on childhood traumatic experiences in the literature have generally focused on physical, sexual, emotional abuse and neglect (17, 28); on the other hand, in this study, the participants mostly gave high scores to the questions of emotional neglect, physical neglect, and emotional abuse. The findings of the study draw attention to the importance of emotional neglect and abuse in substance users. Unlike other forms of abuse in childhood, emotional abuse and neglect are more difficult to define, measure, and differentiate because they do not have physical indicators (29). However, some studies have shown that early life stressors such as childhood traumatic experiences can change the structures of the brain, potentially leading to playing an important role in addictive behaviours (10, 30). The findings of this study reveal that the emotional needs of adults with substance use are mostly neglected during childhood. Some studies report that addiction may occur in adults who have experienced physical and sexual abuse during childhood and think their needs are neglected by their parents (28, 31). Furthermore, 28.6% of the participants reported a family history of substance use. This rate is remarkable in terms of explaining emotional neglect, physical neglect, and emotional abuse reported by the participants. The presence of a family history of substance use is a serious stress factor that an individual will experience in childhood (32). When the findings related to gender were examined in the study, it was determined that the majority of the participants were male. Although this situation is related to the hospitalization policies of the institution where the research was conducted, it reveals the need for similar studies in institutions where women with substance abuse are admitted. In addition, it has been suggested in the literature that women with substance use are generally less likely to seek treatment than men (33).

In this study, substance users mainly adapted the religious coping style. This result is believed to be associated with Islam, which is the most common religion in Turkey. However, no significant relationship was found between this attitude and childhood traumatic experiences ($p>0.05$). It is also possible to investigate the relevant situation in detail with the increase of studies that focus on religious coping as positive and negative religious coping in substance users (34). This situation should be evaluated in more detail with similar studies in which the religious demographic information of the participants is discussed.

Studies suggest that coping attitudes can be greatly influenced by a history of childhood neglect and abuse, and these attitudes may affect the development of psychopathology (35-41). This idea is supported by this study in which a positive correlation between childhood traumatic experiences and denial, behavioural disengagement, use of emotional social support, substance use, and acceptance was found ($p<0.05$). In another study, it was concluded that there was a significant relationship between emotion-focused coping strategies and neglect levels of individuals with a history of childhood neglect, and they use less effective coping strategies than children who have not been neglected (42).

Brammer et al. (2022) stated that childhood trauma experience is related to coping strategies and individuals use cannabis to cope with problems (43). Georgsdottir et al. (2021) reported that participants' substance use is an important coping strategy they perceive to help them cope with challenging emotions (42). The

studies in the literature back up the finding that nearly half of the participants in this study continue to use substances and adopt substance use as a way of coping with stress (40, 42). In addition, Love and Torgerson (2019) (44) reported that traumatic experience in childhood increases the likelihood of substance use to cope with challenging emotions while Kozak et al. (2019) (45) reported that substance use may be related to impulsivity. Studies should be conducted to examine individuals who have experienced childhood traumatic experiences and who use substances in adulthood in terms of impulsivity. Downey and Crummy (2022) reported that childhood trauma is associated with low self-esteem and increased use of substances (46). In line with these results, it can be said that childhood maltreatment may be a strong risk factor for substance use in adulthood (40).

It was concluded in this study that negative childhood experiences have an effect on the use of emotional social support and acceptance, which are emotion-focused coping strategies. This means that the participants develop strategies to reduce their negative effects in the face of stress, but do little to resolve the real cause of stress. In the studies of Sheffler et al. (2019) (47), it was reported that negative experiences in childhood are associated with less use of problem-focused/adaptive coping and more use of emotion-focused coping. The rationale for this association is that maltreated children tend to perceive their environment as threatening and unpredictable, with little opportunity to effect change (47), a result that is similar to the finding of this study. What is different in this study is that it only focuses on the relationship between negative childhood experiences and emotion-focused coping and problem-focused coping strategies, and mental health outcomes. The finding of this study is also supported by the positive relationship between the use of emotion-focused and less useful coping methods in men and childhood trauma in a study conducted on men and women diagnosed with depression (48).

Another finding expected to contribute significantly to the literature is the conclusion that negative childhood experiences have an effect on behavioural disengagement, denial, and substance use strategies, which are inappropriate stress-coping strategies. Even if these strategies are believed to work for a short time to avoid unwanted and compelling emotions, it should be foreseen that they may cause various mental problems as depression and anxiety in the long term (21, 46). In a qualitative study that supports the results of the current study, it was stated that individuals who experienced childhood trauma deny the effects of their trauma history as a coping mechanism and use alcohol-substance use. In the same study, it was concluded that the participants who experienced childhood trauma created a false self in order to prevent social isolation (46). In a study conducted with adults who were sexually abused as children, it was found that participants used inappropriate coping methods such as delaying thoughts, withdrawing from social life, denying experiences, and drug use (49). It is thought that these findings may result from learned helplessness caused by childhood abuse and neglect, and young people's attempts to distance themselves from these stressors instead of confronting them (21).

In this study, substance users mostly use religious coping, experience childhood traumatic experiences at a close-to-moderate level, and mainly give feedback about the lack of meeting their emotional needs in childhood. Furthermore, childhood traumatic experiences have an effect on the development of denial, behavioural disengagement, use of emotional social support, substance use, and acceptance coping attitudes.

The limitations of this study are that the study was carried out in a single institution, the number of women in the study was low due to the hospitalization policies of the institution, and the religious demographic information of the participants was not questioned..

In conclusion, The findings of this study are important for nurses in ensuring that they are aware of the stress coping attitudes most commonly used by individuals with substance use in psychiatric nursing practices and know the coping attitudes that these individuals have been exposed to in childhood. In addition, these results provide important data for future studies on the coping styles of individuals with substance use. In line with this information, it is recommended that psychiatric nurses plan primary, secondary, and tertiary protective-preventive studies, especially within the scope of combating childhood traumatic experiences and

dysfunctional coping attitudes. It is also recommended that they provide individualized and needs-focused care to individuals with substance use to improve functional coping attitudes.

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