Journal of Addictive Diseases, 28:64–67, 2009

ISSN: 1055-0887 print / 1545-0848 online
DOI: 10.1080/10550880802545101

Routledge
Taylor & Francis Group

The Prevalence of Childhood Trauma Among Those Seeking Buprenorphine Treatment

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ABSTRACT. In this study, the authors examined the prevalence of five types of childhood trauma among a sample of adult patients who were addicted to opioids and seeking treatment with buprenorphine. Using a survey methodology, the authors examined a consecutive sample of 113 participants and found that 20.4% reported having experienced sexual abuse, 39.8% reported having experienced physical abuse, 60.2% reported having experienced emotional abuse, 23.0% reported having experienced physical neglect, and 65.5% reported having witnessed violence. Only 19.5% of the sample denied having experienced any of the five forms of childhood trauma. Most respondents (60.2%) reported having experienced one, two, or three different forms of childhood trauma. A minority reported having experienced four (13.3%) or all five (7.1%) forms of childhood trauma. These data indicate that among individuals with opioid dependence who are seeking treatment with buprenorphine, the prevalence rates of various types of childhood trauma are quite high.

KEYWORDS. Addiction, opioid addiction, childhood trauma, sexual abuse, physical abuse, emotional abuse, witnessing violence, physical neglect

INTRODUCTION

In the empirical literature, numerous investigators have described a relationship between childhood trauma and various substance use disorders in adulthood,[1,2] oftentimes mediated by posttraumatic stress disorder. For example, Triffleman, Marmar, Delucchi, and Ronfeldt[3] found that, among male veterans, the number of lifetime substance dependent disorders was strongly and positively correlated with the total amount of childhood trauma exposure. However, the empirical literature related to the relationship between childhood trauma and opioid dependence in adulthood is relatively scant.

Three studies directly address this relationship. In the first, Storey[4] examined 130 opioid addicts and compared with controls found that non-sexual forms of childhood trauma were a significant predictor for subsequent addiction. In a second study, Hien, Nunes, Levin, and Fraser[5] determined the prevalence rates of physical and sexual abuses among 96 opioid-abusing patients, which were 22.9% and 16.7%, respectively.

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Finally, Surratt, Inciardi, Kurtz, and Kiley[6] examined the prevalence of childhood physical and sexual abuses among 325 "sex workers" who were using crack or heroin and found rates of 44.9% and 50.5%, respectively.

Additional studies indirectly provide some insight into the relationship between childhood trauma and opioid addiction in adulthood as well. For example, Rounsaville, Weissman, Wilber, and Kleber[7] describe various substrates for opioid addiction, one which consists of witnessing violence and physical abuse—abuses that occurred in 35% and 17% of their study sample, respectively. Among psychiatric inpatients, Heffernan et al.[8] found that compared with non-abusers, those with opioid abuse were 2.7 times more likely to have a history of sexual or physical abuse. Finally, among opioid-dependent patients, Roy[9] reported a relationship between childhood trauma and suicide attempts.

Not all investigators have confirmed relationships between various types of childhood trauma and opioid addiction. For example, among incarcerated women, el-Bassel et al.[10] did not find any relationships between sexual and physical abuses in childhood and opioid use in adulthood. Likewise, among a small sample of middle-class women, McCoy, McGuire, Curtis, and Spunt[11] did not find any relationship between childhood trauma and heroin use.

In addition to the continuing controversy regarding the relationship between childhood abuse and opioid addiction, few previous studies in this area have examined childhood abuses beyond physical and sexual abuses. In addition, some of the previous study samples are atypical (e.g., sex workers), making the generalization of findings to other populations difficult. Finally, the characterization of opioid use is oftentimes unclear (e.g., episodic use versus dependence). In this study, we wished to examine the prevalence of five types of trauma (i.e., sexual, physical, and emotional abuses; physical neglect; witnessing of violence) among a sample of men and women who were seeking treatment for genuine opioid addiction with buprenorphine, a semi-synthetic mixed agonist/antagonist that is prescribed for opioid dependence.

METHODS

Participants

Participants were males and females, ages 18 years or older, who presented for admission to a sub-acute detoxification unit (i.e., 24-hour care facility) for opioid dependence. The facility is located in a mid-sized, mid-western city. Exclusion criteria were cognitive (e.g., delirium), medical (e.g., acute withdrawal), or psychiatric (e.g., psychosis) impairment that would preclude the successful completion of a survey booklet. Exclusion criteria were assessed by the subject recruiter (PW). A total of 117 candidates were approached; 113 agreed to participate and completed the relevant measures for a response rate of 96.6%.

Of the 113 respondents, 61 (54.0%) were male and 52 (46.0%) were female, ranging in age from 18 to 59 years ($M = 32.87$, $SD = 9.06$). Most (104) participants were White/Caucasian (92.0%); 4 participants were African-American, 3 Hispanic, 1 Asian, and 1 Native American. With regard to educational attainment, most (97; 85.8%) had at least graduated high school, but only 12 (10.6%) had earned a college degree.

Procedure

One recruiter consecutively approached and recruited candidates as they presented for admission to a sub-acute detoxification program that solely uses buprenorphine for the treatment of opioid addiction. After being screened for exclusion criteria, each candidate was asked to participate in a study that "explores relationships between the individual's early childhood environment and opioid addiction." Participants were then asked to complete a 5-page survey booklet, which took approximately 15 minutes. The cover page of the booklet contained the elements of informed consent and completion of the booklet was assumed to be implied consent for participation.

We initially queried participants about demographic information (e.g., age, sex, race/ethnicity, marital status, and education). We then inquired about five author-developed items to explore childhood trauma. Specifically,

participants were asked whether "Prior to the age of 12, did you *ever* experience . . . " with yes/no response options. Items were the following: (1) sexual abuse (defined as "any sexual activity against your will"); (2) physical abuse (defined as "any physical insult against you that would be considered inappropriate by either yourself or others and that left visible signs of damage on your body either temporarily or permanently or caused pain that persisted beyond the 'punishment"'); (3) emotional abuse (defined as "verbal and nonverbal behaviors by another individual that were purposefully intended to hurt and control you, not kid or tease you"); (4) physical neglect (defined as "not having your basic life needs met"); and (5) the witnessing of violence (defined as "the first-hand observation of violence that did not directly involve you"). Scores could range from 0 (none of the 5 types of childhood abuse/trauma) to 5 (all forms). A brief query of trauma was elected because of the busy nature of the study setting, our previous research experience with this measure, and our intent to use a measure that was different than those used in previous studies (i.e., would such a measure replicate the findings of others?).

To protect the confidentiality of participants, the need for signed consent forms was waived by both Institutional Review Boards who approved the project. Participants were not paid for their participation in this study. The Institutional Review Boards of both the community hospital and university approved this project.

RESULTS

Of the 113 respondents, 23 (20.4%) reported having experienced sexual abuse, 45 (39.8%) reported having experienced physical abuse, 68 (60.2%) reported having experienced emotional abuse, 26 (23.0%) reported having experienced physical neglect, and 74 (65.5%) reported having witnessed violence. Only 22 (19.5%) denied having experienced any of the five forms of childhood trauma; most respondents (68; 60.2%) reported having experienced one, two, or three different forms of childhood trauma. A minority reported having experienced four (15;13.3%) or all five (8;7.1%) forms of childhood trauma.

DISCUSSION

These data indicate that the prevalence of various types of childhood trauma among those seeking treatment with buprenorphine (i.e., individuals with genuine opioid addiction) is high. Compared with other studies in the area of opioid addiction, our empirically determined prevalence rates are substantially higher, with the exception of the study of sex workers by Surratt, Inciardi, Kurtz, and Kiley.[6] This latter study, of course, reflects an unusual participant sample. In comparison with the remaining studies with lower prevalence rates, these various study populations may not have reflected individuals with genuine opioid addiction, but rather "opioid use." Thus, it could be that by selecting a study population with genuine opioid addiction (i.e., those seeking treatment with buprenorphine), we may have unintentionally sampled a more psychologically damaged population, which in turn, is reflected in higher rates of various types of childhood trauma.

There may be other explanations for these findings, as well. For example, these high rates of childhood trauma could also be explained by historical distortion by participants. Specifically, perhaps the long-term effects of addiction entail some distortion of one's history, due to the direct effects of opioid drugs on cognition and memory.

In addition, these high rates of childhood trauma might also be explained by participants' unconscious exaggeration of them as a rationale for their drug use and addiction. In other words, the over-endorsement of childhood trauma might function to "explain" to others one's addiction to opioids.

A final explanation may be the age-of-onset of drug use. Perhaps early-onset drug use is more likely in those with opioid addiction, and thus results in behavioral and interpersonal chaos at an early age. In response, family members may have inappropriately managed their precocious drug user by emotionally or physically abusing them. However, this explanation is less likely given the age qualifier for queries about childhood abuse in this study "prior to the age of 12 years."

It is somewhat surprising that the witnessing of violence and emotional abuse were the

childhood traumas most described by the participants in this study. In the current literature, these are the variables that are the least inquired about. Our findings suggest that these specific types of childhood traumas might offer the highest yield.

Given the high prevalence rates of various types of childhood traumas in this sample, one wonders whether there are mediating psychological variables on the road to opioid addiction, such as an Axis I (e.g., major depression, dysthymia, panic disorder, generalized anxiety disorder, or posttraumatic stress disorder) or Axis II (e.g., borderline, antisocial, avoidant, paranoid, or schizotypal personality disorders[12]) disorder. Although not the focus of this study, it would certainly be worthwhile in future studies to examine the relationships between various types of childhood traumas, the Axis I and personality disorders associated with these trauma substrates and opioid addiction in adulthood.

This study has several potential limitations. First, all data were self-report in nature and subject to the vicissitudes of self-report data. Second, our assessment for childhood trauma was fairly rudimentary. Third, there is no control or comparison group in this study. However, this is the first study in this area of scant literature (i.e., opioid-use studies) to: (a) examine a well-defined population of opioid users (i.e., those who are clinically dependent and seeking buprenorphine, rather than a mixed population of users as well as those with addiction); (b) examine five separate types of childhood trauma using a relatively novel assessment measure; and (c) affirm rates of emotional abuse and witnessing violence that actually exceed the rates of other forms of trauma (note that physical and sexual abuses have been frequently indicated in previous studies). In addition, the study population represents a consecutive sample. These findings further refine the previous literature in this area and confirm that individuals with opioid addiction appear to come from difficult and stressful family backgrounds.

Perhaps future studies will broaden their study of childhood trauma variables, examine the possible role of mediating Axis I and II disorders, and examine patient treatment outcomes as a function of childhood trauma. If these data are accurate, we can surmise that individuals with opioid addiction come from emotionally abusive and violent homes that may be intermittently riddled with sexual and physical abuse as well as physical neglect.

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