NEAR EAST UNIVERSITY
GRADUATE SCHOOL OF SOCIAL SCIENCES
CLINICAL PSYCHOLOGY
MASTER'S PROGRAMME

MASTER'S THESIS

A COMPARISON OF CHILDHOOD TRAUMA HISTORY AND PSYCHOPATHOLOGICAL SYMPTOMS AMONG SUBSTANCE DEPENDENTS AND NON-DEPENDENTS

PREPARED BY

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20142418

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NICOSIA
2017

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I am Feriha ÇELİK, hereby declare that this dissertation entitled "A Comparison of Childhood Trauma History and Psychological Symptoms Among Substance Dependents and Non-Dependents " has been prepared by myself under the guidance and supervison of "Prof. Dr. Mehmet ÇAKICI" in partial fulfilment of The Near East University, Graduate School of Social Sciences regulations doesn't need to be the best of my knowledge breach any Law of Copyrights and has been tested for plagarism and a copy of the result can be found in the Thesis.

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ÖZ

Madde Bağımlılığı Tanısı Olan ve Olmayan Bireylerin Çocukluk Çağı Travmaları ve Çeşitli Psikopatolojik Belirtiler Açısından Karşılaştırılması

Hazırlayan: Feriha ÇELİK

Ocak, 2017

Bu araştırmanın amacı, madde bağımlıları ile herhangi bir madde bağımlılığı olmayan bireylerin, Travma Sonrası Stres Bozukluğu (TSSB), çocukluk çağı travmaları ve çeşitli psikopatolojik belirtiler açısından karşılaştırılmasıdır. Araştırmaya toplam 68 katılımcı katılmıştır. Araştırmaya, Barış Ruh ve Sinir Hastalıkları Hastanesine başvurmuş ICD-10 tanı ölçütlerine göre madde bağımlılığı tanısı almış, yatarak veya ayaktan tedavi gören 34 madde bağımlısı erkek hasta ve kontrol grubu olarak 34 sağlıklı erkek bireyler katılmıştır. Araştırmada kullanılan araçlar, Sosyodemografik Bilgi Formu, Post Travmatik Stres Bozukluğu Ölçeği, Çocukluk Çağı Ruhsal Travma Ölçeği, Bağımlılık Profil İndexi, Kısa Semtom Envanter'dir. Araştırmaya katılan katılımcıların yaş ortalaması 40.00 ± 12.31 idi. Araştırmanın sonuçlarına göre, madde bağımlısı olan hastalarda çocukluk çağı travmaları, TSSB ve psikopatoloji, bağımlı olmayan bireylere göre daha fazla bulunmuştur.

Anahtar kelimeler: Madde Bağımlılığı, Psikoaktif Maddeler, Travma, Çocukluk Çağı Travması, Travma Sonrası Stres Bozukluğu

ABSTRACT

A Comparison of Childhood Trauma History and Psychopathological Symptoms Among Substance Dependents and Non-Dependents

Prepared by: Feriha ÇELİK

January, 2017

This study aims to compare substance dependent patients and non-dependents in terms of Post Traumatic Stress Disorder (PTSD), child abuse and psychopathological symptoms. This study's sample consist 68 individuals. These 34 individuals were select from who will admitted to the Barış Mental Hospital who diagnosed as substance dependent according to the criteria of ICD-10 as compared with 34 healthy male controls. All patients were assessed by using a semi- structured Socio-demographic Information Form, Addiction Profile Index (API), Childhood Trauma Questionnaire, Post Traumatic Stress Disorder-Civilian Version and Brief Symptom Inventory. Findings: The mean age of participants was 40.00 ± 12.31. Age interval of the participants was 21-67. According to the findings substance dependent patients have more childhood abuse or neglect history, PTSD and psychopathological symptoms compared with non-dependent people.

Keywords: Substance dependence, Psychoactive Substances, Trauma, Childhood trauma, Post Traumatic Stress Disorder

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ABBREVATIONS

API: Addiction Profile Index

BSI: Brief Symptom Inventory

CM: Child Maltreatment

CPA: Child Physical Abuse

CTQ: Childhood Trauma Questionnaire

DSM: Diagnostic and Statistical Manual of Mental Disorders

ICD-10: The Tenth Revision of the International Classification of Diseases and Health Problems

LSD: Lysergic acid diethylamide

OPD: Other Psychoactive Drug

PCL-C: The Posttraumatic Stress Disorder Check List - Civilian Version

PCP: Phencyclidine

PTSD: Post Traumatic Stress Disorder

SD: Substance Dependents

SPSS: Statistical Package for Social Sciences

TRNC: Turkish Republic of North Cyprus

1. INTRODUCTION

Since the beginning of human history, drugs have been used for pain killer, healing diseases and abolish negative emotions. They have been used for medical purposes in the historical process but pleasurable features increased consumption (Ögel, 1997). Alcohol and substances located in mythological stories, legends, primitive religion, poems, songs, novels. These caused alcohol and substance subculture born, spread and developed in social processes. Substances have effects on central nervous system and changes people's psychological life, feelings, thoughts, behaviors and because of the chemical structure develop dependency in a short and easily way (Köknel,1998). Drug addiction has characterized as a chronic, relapsing illness with people compulsive substance seeking and using and long term brain changes (Nora & Volkow, 2008). The Tenth Revision of the International Classification of Diseases and Health Problems (ICD-10) defined dependence syndrome as the powerful desire to take the psychoactive drugs, alcohol, or tobacco (Dünya Sağlık Örgütü, 1993). Drug addiction is severely damaging the patient, destroys the life, affect the lives of social life. People's unsuccessful attempts to solve their problem take them into addiction world. The drug addicts have self-destructive tendency. He avoids facing up to struggle to obtain drugs and this gives him temporary gratification (Nyswander, 1956). Substance dependence is associated with many psychological factors and psychiatric disorders. In addition, mood disorders and anxiety disorders frequently occur in substance dependents (Arı, 2007). Substance dependence is a disease that biological, psychological, behavioral and social factors have roles on it. Besides the genetic predisposition, learning theories should be considered when the substance dependence causes examining. Behavioral patterns and social risk factors also

affect dependence. Social environment, groups of friends, easy availability to drugs have a huge role on substance dependence (Öztürk & Uluşahin, 2008).

2. LITERATURE REVIEW

The literature firstly review presents a description of substance dependence and secondly overview of child maltreatment, PSTD and historical background, the diagnostic criterias, definitions, prevalance and causes, comorbid problems.

2.1. Definition of Psychoactive Drugs

Drugs are the chemicals that can cause addiction and mental, behavioral, physical changes in person when introduced into the body. They called psychoactive drugs in medical literature. Because of the word of "drug" also used for medicine, recently they called as "substance" rather than "drug" (Ögel, 2010). Psychoactive substance use can lead to dependence syndrome (Dünya Sağlık Örgütü, 1993).

2.1.1. History of the Addictive Drugs

Since the beginning of human history, drugs have been used for pain killer, healing diseases and abolish negative emotions. They have been used for medical purposes in the historical process but pleasurable features increased consumption (Ögel, 1997). Alcohol and substances located in mythological stories, legends, primitive religion, poems, songs, novels. These caused alcohol and substance subculture born, spread and developed in social processes (Köknel,1998). Alcohol is the first substance that we know from the written documents in history. Grape and wine were accepted sanctified by Ancient Rome and Greek (Uzbay, 2011). History shows that substance using take a form by culture, society, religion and beliefs, personalities, cognition, neurobiology and genetics. Psychoactive substances have been used in rituals for medical purposes by monks or shamans for thousand years. They used plants for religious rituals. Hashish (cannabis) has

been largely consumed in Islamic cultures by eaten and later smoked. Some drugs have been used as medications. The medical use of opium was defined from the oldest inscriptive records. Opium is one of the drugs which usage has been changed in last centuries, it has been used for medication and anesthesia but nowadays use to abuse and dependence (Crocq, 2007). In the 1960s and 1970s researchers believed that substance abuse was rare in the elderly and because of that, until the past two decades, alcohol and drug abuse was rarely discussed in elderly as compared to younger adults. Even today, the frequency of substance problems climbs in older adults, it remains largely an invisible undiagnosed and undertreated (Oslin & Klaus, 2009). Opium has been used for medical purposes for thousands of years. Cannabis can be seen in old Chinese plants. In 18th and 19th centuries, opium smoking was an important problem in Asia. Technology also influenced the use of tobacco (Strain & Anthony, 2009).

Substance dependence and addictive drugs were not accepted as a serious health problem until 1990's. Substance abuse causes, treatment and prevention studies had increased since 1980's (Uzbay, 2011).

2.1.2. Definition of Dependency

Drug addiction has characterized as a chronic, relapsing illness with people compulsive substance seeking and using and long term brain changes (Nora & Volkow, 2008). Dependence is body's physical needs to using drugs irresistible form. Substance dependence can be physical and psychological (Ögel, 2010). The Tenth Revision of the International Classification of Diseases and Health Problems (ICD-10) defined

dependence syndrome as the powerfull desire to take the psychoactive drugs, alcohol, or tobacco (Dünya Sağlık Örgütü, 1993).

Drug addiction is severely damaging the patient, destroys the life, affect the lives of social life. Non-addict people have always curious about what drives a person to become a drug addict. People's unsuccessful attempts to solve their problem take them into addiction world. The drug addicts have self-destructive tendency. He avoids facing up to struggle to obtain drugs and this gives him temporary gratification (Nyswander, 1956). The presence of one or more significant and recurring psychosocial, interpersonal or legal problems related to substance use is defined as substance abuse, whereas substance dependence requires 3 or more severe, recurring problems related to use within a 12 months period and may include tolerance withdrawal and wide use (Oslin & Klaus, 2009). Substance Dependence is defined as a maladaptive pattern of substance use cause to clinically significant impairment or distress in DSM-IV. Dependency has several components. Tolerance is defined by a condition that user needs more and more of the drug to experience the same effect. Withdrawal refers to physical and psychological symptoms when the drug intake is stopped or reduced. To have a consistent desire or unsuccessful struggle to cut or control substance use (American Psychiatric Association, 2001). The 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) doesn't separate the diagnoses of substance abuse and dependence as in DSM-IV. The DSM-5 eliminates the terms "abuse" and "dependence" from diagnostic categories and uses under one category called "Substance Use Disorder" (American Psychiatric Association, 2013).

Table 1.

Criterias of Substance Use Disorders According to the DSM-5

A. A problematic pattern of substance use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12 months period:

1. The substance is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control the substance use.
3. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from it's effects.
4. Craving, or a strong desire or urge to use the substance.
5. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued Substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.
7. Important social, occupational, or recreational activities are given up or reduced because of substance use.
8. Recurrent substance use in situations in which it is physically hazardous.
9. Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
    b. A markedly diminished effect with continued use of the same amount of the substance.
11. Withdrawal, as manifested by either of the following:
    a. The characteristic withdrawal syndrome for the substance (refer to criteria A and B of the criteria set for alcohol or other substances withdrawal)
    b. Substance (or closely related substance, such as benzodiazepine with alcohol) is taken to relieve or avoid withdrawal symptoms.

Specify;

- With physiological dependence: evidence of tolerance or withdrawal (i.e. either item 4 or 5 is present.
- Without physiological dependence: no evidence of tolerance or withdrawal (i.e. neither item 4 or 5 is present.

Table 2.

F1x.1 Criterias of Harmful use According to the ICD-10

A. Clear evidence that the substance use was responsible for (or substantially contributed to) physical or psychological harm, including impaired judgement or dysfunctional behavior.
B. The nature of the harm should be clearly identifiable (and specified).
C. The pattern of use has persisted for at least one month or has occurred repeatedly within a twelve-month period.
D. The disorder does not meet the criteria for any other mental or behavioral disorder related to the same drug in the same time period (except for acute intoxication F1x.0).

Table 3.

F1x.2 Criteria of Dependence Syndrome According to the ICD-10

A- Definite diagnosis of dependence should usually be made only if three or more of the following have been present together at some time during the previous year:
(a) a strong desire or sense of compulsion to take the substance;
(b) difficulties in controlling substance-taking behavior in terms of its onset, termination, or levels of use;
(c) a physiological withdrawal state (see F1x.3 and F1x.4) when substance use has ceased or been reduced, as evidenced by: the characteristic withdrawal syndrome for the substance; or use of the same (or a closely related) substance with the intention of relieving or avoiding withdrawal symptoms;
(d) evidence of tolerance, such that increased doses of the psychoactive substances are required in order to achieve effects originally produced by lower doses (clear examples of this are found in alcohol- and opiate-dependent individuals who may take daily doses sufficient to incapacitate or kill non-tolerant users);
(e) progressive neglect of alternative pleasures or interests because of psychoactive substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects;
(f) persisting with substance use despite clear evidence of overtly harmful consequences, such as harm to the liver through excessive drinking, depressive mood states consequent to periods of heavy substance use, or drug-related impairment of cognitive functioning; efforts should be made to determine that the user was actually, or could be expected to be, aware of the nature and extent of the harm.

2.1.3. Causes of Substance Use

Substance dependence is a disease that biological, psychological, behavioral and social factors have roles on it. Besides the genetic predisposition, learning theories should be considered when the substance dependence causes examining. Behavioral patterns and social risk factors also affect dependence. Social environment, groups of friends, easy availability to drugs have a huge role on substance dependence (Öztürk & Uluşahin, 2008). Genetic factors also effects on substance use. Twin and adoption studies showed that genetic factors have an important role on Alcohol-Substance using (Oslin & Klaus, 2009). Environmental factors also effects substance using. Social and environmental factors have significant roles in the substance use disorders. Socio-cultural factors include substance availability, acceptability, environmental impacts. Substance costs and easy availability, increase the risk of substance abuse (Demoss, 1992).

2.1.4. Classification of Addictive Drugs

- Tobacco
- Alcohol
- Opiates: Heroin, Morphine, Codeine, Methadone.
- Stimulants: Amphetamine, Cocaine, Ecstasy, Caffeine
- Depressants (Benzodiazepines): Barbiturates, Benzodiazepines (Diazem, Xanax, Ativan, Rivotril, Rohypnol etc), Akineton
- Hallucinogens: LSD (Lysergic acid diethylamide), PCP –Phencyclidine
- Volatiles : Glue, Thinner, Gasoline
- Cannabis : Marijuana

- Phencyclidine (PCP)

All of the addictive substances are not illegal substances. Some of them can be found in pharmacies legally (Ögel, 2010).

2.1.4.1. Tobacco

Tobacco is one of the most widely used in the world currently. The original ingredient is nicotine. Tobacco contains nicotine, tar and carbon monoxide. Appetite suppressant, risk of heart attack and heart disease, causes blood vessels to tighten and restricts blood flow are the side effects of using tobacco (Ögel, 2010).

2.1.4.2. Alcohol

Alcohol has both stimulatory and sedative effects as nicotine. Because of easy accessibility, frequency of alcohol use increase day by day in the society and slow intoxication after a long time use, alcohol constitutes a big social danger (Kurupınar, 2012).

2.1.4.3. Cannabis

The botanical name of the hemp plant is “cannabis sativa”. Length ranges between 1-3 meters. To production, collect their sheets. In America and Western countries it defined as “marijuana” (Şahin, 2007). Marijuana is a drug derived from the flowering tops of a variety of hemp plants. Marijuana’s most common effects are period of euphoria lasting about 2 hours and sexual stimulation. Especially as smoked in cigarettes or may be taken by mouth combined with liquids (Nyswander, 1956). Cannabis contains 421 varieties chemicals. The active ingredient is a tetrahydrocannabinol (THC). Use of cannabis can

cause panic, fear, doubt state. Cannabis can cause memory disorders and loss of concentration. Cannabis users have seven times more risk to be Schizophrenia than not users. Frequent and prolonged use increases the risk (Ögel, 2007).

2.1.4.4. Hallucinogens

Hallucinogens can make you hallucinate. Hallucinogens have effects like visual hallucinations, depersonalization, derealization, anxiety, can cause you to panic, become paranoid, vitality, mobility, increased energy, versus proximity to opposite sex, confidence, warmth, perception changes seen. LSD, ecstasy, Magic mushrooms, Fensiklidin (PCP) are all hallucinogens. LSD is the most known hallucinogens. It shows the effect of 20 to 60 minutes and the effect lasts 4-6 hours. Mostly found in entertainment places (Köroğlu & Cengiz, 2007).

2.1.4.5.Volatiles

Volatiles are widely use substances. They are both cheap and legal. Paint, paint thinner, butane gas, gasoline, Tipp-Ex, adhesives like bally and glue are all volatiles. Volatiles can behave aggressive and dangerously. Volatiles can cause sudden death and have negative effects on brain and heart. Withdrawal symptoms are sleep disorders, palpitations, disorientation, extreme irritability, restlessness, sweating, nausea, vomiting, tremor (Ekşi et.al., 1998).

2.1.4.6. Heroin

Heroin is a highly addictive and dangerous drug. Heroin can be smoked in cigarette, sniff the powder, inject it directly into veins with syringes. The drug's effects last for 3-4 hours. Euphoria, loss of pain sensation, flushing, increased blood pressure, low respiratory and heart rate can be seen. The overdose can cause low respiratory, coma and death (Nyswander, 1956).

2.1.4.7. Ecstasy

Ecstasy taken orally, usually as a capsule or tablet. The drug's effects last approximately 4 to 6 hours and usually sold in nightlife. Increased energy, euphoria, emotional warmth and empathy toward opposite sex can be seen. Dependence potential is low. Withdrawal symptoms are fatigue, headache, dizziness (Ögel, Taner, & Yılmazçetin, 2003).

2.1.4.8. Cocaine

It obtained from the leaves of the Erythroxylon coca tree. This tree is native to South America and Mexico. The drug's effects are visual hallucinations, a feeling of great mental and physical power. Addicts may inject cocaine or sniff the powder (Nyswander, 1956).

2.1.4.9. Amphetamines

Amphetamines are Central Nervous System stimulants. It made from core of Phenethylamine. Benzedrine, Dexedrine, Desoxyn, Ritalin, Preludin are used widely (Köknel, 1998).

2.1.5. Withdrawal Symptoms and Tolerance

Physical or psychological symptoms that occur after use of a drug is reduced abruptly or stopped defined as withdrawal symptoms. Tolerance refers to a physiological state higher dose drug need in order to achieve the same effect (Köknel, 1998). Withdrawal is mostly related with the dependency. In general, the severity, the symptoms of withdrawal is associated with the class of drug, amount of the drug and the time and type of use. Withdrawal can seen when the use of the substance is cut down and also when reduced use and a change metabolism (Strain & Anthony, 2009).

Table 4.

Mental and behavioral disorders due to psychoactive substance use according to ICD-10

F10.- Mental and behavioral disorders due to use of alcohol
F11.- Mental and behavioral disorders due to use of Opioids
F12.- Mental and behavioral disorders due to use of Cannabinoids
F13.- Mental and behavioural disorders due to use of sedatives or hypnotics
F14.- Mental and behavioural disorders due to use of cocaine
F15.- Mental and behavioural disorders due to use of other stimulants, including caffeine
F16.- Mental and behavioural disorders due to use of hallucinogens
F17.- Mental and behavioural disorders due to use of tobacco
F18.- Mental and behavioural disorders due to use to volatile solvents
F19.- Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances

2.1.6. Prevalance of Substance Use in T.R.N.C.

Prevalence studies among university students made on dependents showed that Marihuana was the most commonly used OPD in T.R.N.C. University students use OPD mostly within a group of friends and at their homes (Çakıcı & Çakıcı & Eş & Ergün, 2014). Barış Mental Hospital's reports are showed that there is a significant increase on alcohol and substance dependent inpatients in 2014. Between the years of 1996-1999, 2000-2003 and 2011-2014, the number of alcohol and substance dependent inpatients has increased. In 2011 the rate of inpatients with diagnose of dependence syndrome was 20% but in 2014 ratio of inpatients with diagnose of dependence syndrome was increased 34% (Akbirgün, 2015). The most commonly used substance defined as Cannabis in TRNC. Kyrenia, Nicosia and Famagusta is the most common places for drug use. Substance use starting age between 15-30 years and very common in University students (Çakıcı, 1998). In another researches reported that the males are uses substances more often than females. In a research conducted in TRNC showed that illicit psychoactive drug use increased (Çakıcı, Paşa, & Görkem, 2012). Especially Cannabis and Ecstasy using rates showed significant increase. The prevalence of alcohol use 77.1% illicit drug use 7.7% in TRNC. The most common use OPD were Cannabis, Ecstasy and Bonsai (Çakıcı, Çakıcı, Karaaziz, Tütar, & Çakıcı, 2014). According to recent studies, substance abuse has fully increased in TRNC. Results show that lifetime use of all legal and illegal substances among women was lower when compared to men and especially the prevalence is high among males and adolescent population. In recent years, there were no distinct increases in cigarette and alcohol use but there was an observable increase in other psychoactive substance use when compared to earlier years (Çakıcı, Çakıcı, & Ergün, 2015).

2.1.7. Epidemiology of Drug Use

It's hard to make epidemiological studies to evaluate the prevalence of substance use disorders. The reasons are;

- Because of the substance use is illegal, users tend to be hidden
- During the surveys, they may not give the right answers
- The number of substance dependent is low rate in general population. Because of that it is hard to reach to small group in the general population
- With survey studies it is hard to put the diagnoses of addiction, only users can be determined

Because of these causes, hospitals, police, court, prison records uses to determine the prevalence of addiction. In 2003 in a survey conducted among students prevalence of lifetime cannabis use at least one time was found 3.3% in Adana, 2.9% in Ankara, 5.1% in Diyarkakır, 6.1% in İzmir, and 3.8% in Samsun by United Nations Office on Drugs and Crime (UNODC). The results showed that the prevalence of lifetime ecstasy use at least one time was 1% in Adana, 1.1% in Ankara, 0.6% in Diyarkakır, 2.5% in İzmir, and 0.8% in Samsun (Ögel, 2007).

Recent reports showed that substance use in adults from 50 to 54 years old has severe increase in illicit drug use in this age group from 3.4 to 6.0 % between the years of 2002 to 2006, whereas there was not a significant use in those aged 55 to 59 years (Oslin & Klaus, 2009). In 2000 the mean age of starting substance use was found 17.2 (Sevinçok, Küçükardalı, Dereboy, & Dereboy, 2000) and Bulut et al. (2006) was found mens were more often use substances and the mean age of starting use substances was 22.44.

2.2. Trauma and Post Traumatic Stress Disorder

2.2.1. History of PTSD

The biggest progress to understand the impact of psychological adjustment of life-threatening traumatic stressors was wartime military responses. They lost their time, place, orientation or dissociative symptoms were observed such as amnesia and depersonalization (Doğan, 2001). PTSD has been known under various names throughout military history, including the ‘irritable heart of the soldiers’, ‘combat neurosis’, ‘war neurosis’ and ‘shell-shock’. During the World War I, soldiers reported some clinical symptoms. It was describing as the effects of explosions from artillery shells and the term "shell shock" came into describe these reactions (Gersons & Carlier, 1992).

In 1952, in the first Diagnostic and Statistical Manual of Mental Disorders (DSM-I) included ‘‘Gross Stress Reaction’’. This identification includes traumatic events like disaster, war. DSM-II included ‘‘adjustment reaction to adult life’’ (Friedman, 2013). In the 1960s the Vietnam War has an important experience to forming this clinical table as a consequence of traumatic events. With these experiences in 1980, APA added Post Traumatic Stress Disorder to the third edition in Diagnostic and Statistical Manual of Mental Disorders (Özmenenler, 2007).

2.2.2. Definition of PTSD

Trauma defined to strong events such as accidents, earthquakes, hurricanes, floods, volcanoes, etc., crimes, surgeries, deaths, and also recurring experiences such as child abuse and neglect (Giller, 1999). In a research conducted in Turkey, found that additional diagnosis of PTSD in male alcohol dependent patients was 32.1% and childhood abuse history rate was significantly higher (Dalbudak, 2008). Trauma and PTSD causing to increase alcohol and substance using (Aldemir & Tan, 2011)

DSM, 4th edition, explained a trauma which the person direct experienced or witnessed or was be faced with a traumatic event that threatened death, serious injury, or a threat to the physical integrity of self or others. The person responses to these events with intense fear or helplessness. The symptoms of the PTSD exist more than 1 month. If the duration of symptoms is less than 3 months it defined as Acute Stress Disorder. Symptoms lead to significant distress, impairment in social life, occupational life, or other functioning (Amerikan Psikiyatri Birliği, 2001). The 5th edition of the Diagnostic and Statistical Manual of Mental Disorders reflects many changes in PTSD criteria. The DSM-5 is more lightened in what is a traumatic event and PTSD is no more classified as an anxiety disorder and it classified as ‘‘Trauma and Stress-Related Disorders’’ in DSM-5. Especially sexual assault is included in first criteria in DSM-5. DSM-5 criterias include:

- Re-experiencing the traumatic event
- Heightened arousal (aggressive, reckless or self-destructive behavior)
- Avoidance of distressing memories, thoughts, feelings or events

- Negative thoughts and mood or feelings (Grohol, 2013).

Table 5.

Criteria of Post Traumatic Stress Disorder According to the ICD-10

A. Exposure to a stressful event or situation (either short or long lasting) of exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone.
B. Persistent remembering or "reliving" the stressor by intrusive flash backs, vivid memories, recurring dreams, or by experiencing distress when exposed to circumstances resembling or associated with the stressor.
C. Actual or preferred avoidance of circumstances resembling or associated with the stressor (not present before exposure to the stressor).
D. Either (1) or (2):
(1) Inability to recall, either partially or completely, some important aspects of the period of exposure to the stressor
(2) Persistent symptoms of increased psychological sensitivity and arousal (not present before exposure to the stressor) shown by any two of the following:
a) difficulty in falling or staying asleep;
b) irritability or outbursts of anger;
c) difficulty in concentrating;
d) hyper-vigilance;
e) exaggerated startle response.
E. Criteria B, C and D all occurred within six months of the stressful event, or the end of a period of stress.
(For some purposes, onset delayed more than six months may be included but this should be clearly specified separately.

Table 6.

Criteria of PTSD According to the DSM-V

A.The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows: (one required)

1. Direct exposure.
2. Witnessing, in person.
3. Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
4. Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures.

B. The traumatic event is persistently re-experienced in the following way(s): (one required)

1. Recurrent, involuntary, and intrusive memories. Note: Children older than six may express this symptom in repetitive play.
2. Traumatic nightmares. Note: Children may have frightening dreams without content related to the trauma(s).
3. Dissociative reactions (e.g., flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness. Note: Children may reenact the event in play.
4. Intense or prolonged distress after exposure to traumatic reminders.
5. Marked physiologic reactivity after exposure to trauma-related stimuli.

C. Persistent effortful avoidance of distressing trauma-related stimuli after the event: (one required)

1. Trauma-related thoughts or feelings.
2. Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).

D. Negative alterations in cognitions and mood that began or worsened after the traumatic event: (two required)

1. Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol, or drugs).
2. Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous").
3. Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.
4. Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest in (pre-traumatic) significant activities.
6. Feeling alienated from others (e.g., detachment or estrangement).
7. Constricted affect: persistent inability to experience positive emotions.

E. Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event: (two required)

1. Irritable or aggressive behavior
2. Self-destructive or reckless behavior
3. Hypervigilance
4. Exaggerated startle response
5. Problems in concentration
6. Sleep disturbance

F. Persistence of symptoms (in Criteria B, C, D, and E) for more than one month.

G. Significant symptom-related distress or functional impairment (e.g., social, occupational).

H. Disturbance is not due to medication, substance use, or other illness.

Painful and severe impacts, unexpected qualities, helplessness, lack of environmental support are common features of traumatic event in PTSD (Öztürk, 2008).

PTSD risk factors are;

- pre-trauma factors,
- female gender,
- Being single, widowed or divorced ,
- Low educational levels,
- Story of the trauma,
- History of mental illness,
- History of negative life events,
- Factors associated with the trauma,
- Severity of the trauma,
- Perceived severity of the trauma,
- Traumatic loss,
- Post traumatic factors,
- Faulty coping strategies,
- Lack of social support (Öztürk, 2008, p. 503).

2.3. Child Maltreatment

Children maltreatment refers to the physical, sexual, emotional abuse, neglect and negligent treatment of children. Child maltreatment may be omissions by parent, other caregivers, friends or strangers intentionally. CM causes physical mental damage on child development. CM is an internationally serious public, health, legal and social issue (WHO, 2006). Trauma experiences in childhood can have long-term effects. Trauma can interrupt developmental processes in childhood. Children who had abuse can have lower levels of self esteem. Adults who have traumatic experiences during the first eighteen years of life are tend to be smoking, obesity, physical inactivity, depressed mood, suicide attempts, alcoholism and substance use (Cari, 2010). Among substance dependent inpatients, suicide attempt history was higher who had Childhood abuse or neglect history in İstanbul, Turkey (Evren & Evren, 2006).

2.3.1. Physical Abuse

Child physical abuse explained as intentional physical act that causing physical injury (e.g., spanking). Boys are more risk for CPA than girls (Perrin & Perrin, 2007).

2.3.2. Emotional (Psychological) Abuse

Emotional abuse is the psychological and social deficiency in the development of a child by parent or other caregivers (Polat, 2007a).

2.3.3. Sexual Abuse

Child is used for the sexual stimulation of an adult or significant older child. It is done as a result of force (Polat, 2007b).

2.3.4. Neglect

A deficit in meeting a child's emotional needs, physical care, medical care by parents or caregivers. Physical neglect and emotional neglect are two main types of child neglect (Polat, 2007).

2.4. Childhood Trauma History, PTSD and Substance Use Relations

Substance abuse severity and childhood physical abuse are associated with each other. Patients with substance abuse have high rate of physical abuse in their childhood. Patients with physical abuse in their childhood are significantly have more rates to have family with substance use disorder and had more family problem like not having a current family (divorced or separated) or not keeping contact with the family (Westermeyer, Wahmanholm & Thuras, 2001). According to Evren and Evren (2006) substance dependents with childhood abuse have high rates of suicide attempt history (Evren & Evren, 2006). Anxiety, physical neglect and sexual abuse are predictive factors for substance dependence (Evren & Ögel, 2003). In a research that conducted in Alaska, 71.9% of 193 alcohol and substance user women had physical or sexual abuse in their childhood (Brems & Namyniuk, 2002).

According to Messman- Moore and Brown (2004), college students study showed that 17% of women have childhood abuse. 8.9% have sexual abuse, 4.2% have physical abuse and 8.6% have emotional abuse in their childhood (as cited in Şahindemirkapı, 2013).

Wolfe and friends (2001) were examined childhood maltreatment and psychological problems of adolescents. Girls with a history of childhood abuse had a higher risk of anger, anxiety and PTSD compared with girls without a history of childhood abuse. Boys with a history of childhood abuse were 2.5 to 3.5 times more likely to have depression, posttraumatic stress, and overt dissociation compared with boys without a history of childhood abuse. Past study showed that PTSD increases the substance use (Epstein, Saunders, Kilpatrick & Resnick, 1998). Meisler (1996) defined that PTSD was prevalent in alcohol and substance users.

Children who abused or neglected are more likely to have depression symptoms, behavioral disorders, learning difficulties, often use of alcohol and addictive substances, violence of themselves or others (suicide), delay of speech, school failure, low self-esteem (Güler, Uzun, Boztaş, & Aydoğan, 2002). According to a study conducted in Bakırköy Mental Health and Neurological Disease Education and Treatment Hospital, Evren and Ögel (2003) found the relationship between dissociative symptoms caused by childhood trauma history, depression, anxiety and substance dependence. In this study conducted with alcohol and substance dependent patients, it was found that childhood emotional abuse and physical neglect are high points.

2.5. Aim of the Study

The aim of the study is to compare substance dependent patients and non-dependents in terms of PTSD, history of child abuse and psychopathological symptoms.

3. METHOD

3.1. The Purpose of the study

The purpose of this study is to compare substance dependent patients and non-dependents in terms of PTSD, history of child abuse or neglect and psychopathological symptoms.

3.2. Hypothesis

The hypothesis of the study;

1. Substance dependent patients have experienced more psychological trauma than non-dependents.
2. Substance dependent patients have been exposed to child abuse more than non-dependents.
3. Substance dependent patients have more psychological symptoms than non-dependents.

3.3. Sampling

Totally 68 males participated in this study. 34 of them were selected from patients who applied to the Barış Mental Hospital in Nicosia, North Cyprus between March 2016 and May 2016. The sample consisted of 34 patients diagnosed as Substance Dependence according to the criteria of ICD-10 as compared with 34 healthy controls. The dependent group was selected according to International Statistical Classification of Diseases and

Related Health Problems 10th Revision (ICD-10) criteria for substance dependence. The Ethical Committee of the hospital approved the study. The Control group was 34 males who did not suffer from any drugs or alcohol dependence, showed no any psychiatric diagnoses and agreed to be in the study. The purposive sample technique was used to obtain controls. The controls were matched with the SD subjects by age, sex and educational levels. All patients were given informed consent after full explanation of the study.

3.3.1. Including Criteria

1. Willingness to participate to study,
2. Being literate,
3. Being male,
4. Meet the diagnostic criteria of Substance Dependence according to ICD-10

3.3.2. Excluding Criteria

1. Age below 18,
2. being female,
3. illiteracy,
4. mental retardation,
5. Cognitive impairment or
6. Comorbid psychotic disorder

3.4. Questionnaire

All patients were assessed by using a semi- structured Socio-demographic Information Form, Addiction Profile Index, Childhood Trauma Questionnaire, Post Traumatic Stress Disorder-Civilian Version, Brief Symptom Inventory.

3.4.1. Demographic Information Form

All the patients assessed by using a semi-structured demographic information form was designed for this study which includes questions about gender, age, education, marital status, country, income level and other personal information.

3.4.2. Addiction Profile Index (API)

The API is a self-report questionnaire and is developed by Ogel K, et al. It includes different components of dependency. API consists of 37 items and 5 subscales. These five subscales measure the characteristics of substance use, dependency diagnosis, substance use effects, craving, motivation to quit from using substances. The subscale's Cronbach's alpha coefficient was 0.89 for the total scale and 0.63 and 0.86 for Correlation coefficients for item-total scores were between 0.42 and 0.89, and those for subscale-total scores were between 0.47 and 0.86. For total API cut-off score was 4, the scale's sensitivity 0.85 and specificity was 0.78. (Ögel, Evren, Karadağ, & Gürol, 2012).

3.4.3. The Childhood Trauma Questionnaire (CTQ)

The CTQ consists of 28 questions. The CTQ is a self-report questionnaire and evaluates abuse and neglect histories of childhood or adolescence. The CTQ was developed by Bernstein DP, et al. in 1994 and Turkish reliability and validity study made

by Vedat Şar, Erdinç Öztürk, Eda İkikardeş in 2012. The questionnaire consist questions related to physical abuse, emotional abuse, sexual abuse, emotional neglect and physical neglect. Cronbach's alpha coefficient for the total scale was 0.93. The Cronbach Alpha coefficients were determined to be emotional abuse (r=0.90 p=0,001) emotional neglect (r=0,85 p<0,001), physical abuse (r=0,90 p<0,001), sexual abuse (r=0,73 p<0,001), physical neglect (r=0,77 p<0,001) (Şar & Öztürk, 2012).

3.4.4. The Posttraumatic Stress Disorder CheckList - Civilian Version (PCL-C)

The PCL-C was developed by Weathers, Litz, Huska and Keane in 1993. Turkish reliability and validity study made by Neşe Kocabaşoğu, Aytül Çorapçıoğlu Özdemir, İlhan Yargıç and Pakize Geyran. It is an easily administered 17- items. It is a self-report questionnaire for assessing the 17 DSM-IV symptoms of PTSD. The scale is a five point Likert type scale ranging from 'not at all' to 'extremely'. For cut-off points of PCL-C is 22\23, both sensitivity and specificity were over 70%. Cronbach alpha of PCL-C was 0. 922 (p<0.0001). The validity of PCL-C with respect to CAPS and PCL-C subscale scores were found total PCL-C score (r=0.655, p<0.001) and intrusion (r=0.618, p<0.001), hyperarousal (r=0.563, p<0.001), avoidance (r=0.458, p<0.001) (Aydemir, 2012).

3.4.5. Brief Symptom Inventory (BSI)

BSI contains 53 questions and it is a self-report symptom inventory. The BSI was developed by Derogatis (1992) and it is the short version of the Symptoms Checklist-90 (SCL-90-R). It measures nine patterns of clinically relevant psychological symptoms Nine symptom dimensions the scale measures are: Somatization, Obsession-compulsion,

Interpersonal sensitivity, Depression, Anxiety, Hostility, Phobic anxiety, Paranoid ideation, Psychoticism. The scale is a five point Likert type scale ranging from ‘not at all’ to ‘extremely’. Administration takes less than 10 minutes (Derogatis, 1992). Turkish reliability and validity study made by Şahin and Durak (1994). According to the factor analysis results, it has been found the inventory including 5 factors. They have named these five sub-dimensions as 14 item related to depression, 17 items related anxiety, 9 items related to negative self-concept, 7 items related to somatization and 4 items related to hostility (Şahin & Durak, 1994).

3.5. Statistical Analysis

In this study, statistical analyzes was perform with Statistical Package for Social Sciences (SPSS 21). A chi-square test was used to evaluate the differences between groups. To evaluate the differences between the means of the two groups t-test was use were used. Additionally, the Pearson Correlation statistical method was used to evaluate correlation between the API and BSI subscales.

4. RESULTS

In the present study 34 (50%) participants were in Substance Dependent Group and 34 (50%) of them were in the Control Group. There were total of 68 participants. Because of the illegal drug research, difficulties of access, time disabilities to drug users can't reach the number of 50 cases. The mean age of participants was 40.00 ± 12.31. Age interval of the participants was 21-67. The participants were retrieved from psychiatry inpatient and outpatient units (substance dependents group) and control group. The two groups were compared according to scores of CTQ, PCL-C and BSI.

4.1. Frequency Tables of Psychoactive Substances

Table 7.

The frequency of substance use

Substances	**Never**	**Only 1-2 times**	**1-3 times in a month**	**1-5 times in a week**	**Almost every day**	**Total**
	n (%)	**n (%)**	**n (%)**	**n (%)**	**n (%)**	**n (%)**
Bonsai	7 (20.6)	9 (26.5)	0(0)	2(5.9)	16(47.1)	34 (100)
Cannabis	9 (26.5)	2 (5.9)	6 (17.6)	5(14.7)	12(35.3)	34 (100)
Ecstasy	22 (64.7)	5 (14.7)	2 (5.9)	4 (11.8)	1 (2.9)	34 (100)
Heroin	15 (44.1)	4 (11.8)	0(0)	3 (8.8)	12 (35.3)	34 (100)
Cocaine	18 (52.9)	6 (17.6)	5 (14.7)	4 (11.8)	1 (2.9)	34 (100)
Hallucinogens	28 (82.4)	3 (8.8)	1 (2.9)	1 (2.9)	1 (2.9)	34 (100)

In the study, n=16 (47.1) participants were use Bonsai almost every day, n=9 (26.5) participants were used only 1-2 times, n=7 (20.6) were use never and n=2 (5.9) were use Bonsai 1-5 times in a week, n=9 (26.5) participants were never use Cannabis, n=2 (5.9)

participants were used only 1-2 times, n=6 (17.6) participants were use 1-3 times in a month, n=5 (14.7) were use 1-5 times in a week and 12 (35.3) participants were use Cannabis almost every day.

Our results showed that, n=22 (64.7) participants were never use Ecstasy, n=5 (14.7) participants were used only 1-2 times, n=2 (5.9) participants were use 1-3 times in a month, n=4 (11.8) were use 1-5 times in a week and n=1 (2.9) participants were use Ecstasy almost every day. We found that, n=15 (44.1) participants were never use Heroin, n=4 (11.8) participants were used only 1-2 times, n=3 (8.8) were use 1-5 times in a week and n=12 (35.3) participants were use Heroin almost every day. According to the results, n=18 (52.9) participants were never use Cocaine, n=6 (17.6) participants were used only 1-2 times, n=5 (14.7) participants were use 1-3 times in a month, n=4 (11.8) were use 1-5 times in a week and n=1 (2.9) participants were use Cocaine almost every day, , n=28 (82.4) participants were never use Hallucinogens, n=3 (8.8) participants were used only 1-2 times, n=1 (2.9) participants were use 1-3 times in a month, n=1 (2.9) were use 1-5 times in a week and n=1 (2.9) participants were use Hallucinogens almost every day.

Table 8.

Treatment history of substance dependents

	Substance Dependents	
	n	%
Yes	29	85.3
No	5	14.7
Total	34	100

In substance dependents group; 29 (85.3%) participants had psychological or psychiatric treatment before and 5 (14.7%) participant had no psychological or psychiatric treatment before.

4.2. Comparison of Demographic Characteristics of Substance Dependence and Non-Dependents

Table 9.

Comparison of ages and substance dependents and control group

Ages	Substance Dependents		Control Group	
	n	%	n	%
18-35 ages	18	52.9	14	41.2
36-45 ages	7	20.6	5	14.7
46 and over	9	26.5	15	44.1
Total	34	100	34	100

X^2=2.333, p=0.311

In the present study 18 (52.9%) participants were 18-35 ages, 7 (20.6%) participants were between 36-45 ages, 9 (26.5%) participants were between 46 and over ages in substance dependents group. 14 (41.2%) participants were 18-35 ages, 5 (14.7%) participants were between 36-45 ages, 15 (44.1%) participants were 46 and over in control dependents group.

Table 10.

Comparison of marital status of substance dependents and control group

	Substance Dependents		Control Group	
	n	%	n	%
Single	22	64.7	17	50.0
Married	12	35.3	17	50.0
Total	34	100	34	100

X^2=1.503, p=0.220

When marital status of substance dependents and control group groups were compared with chi- square analysis, no significant difference was found. According to the results, 22 (64.7%) participants were single, 12 (35.3%) participants were married in Substance Dependent Group. 17 (50.0%) participants were single, 17 (50.0%) participants were married in Control Group.

Table 11.

Comparison of education levels of substance dependents and control group

	Substance Dependents		Control Group	
	n	%	n	%
Primary school	13	38.2	6	17.6
Middle, High school and University	21	61.8	28	82.4
Total	34	100,0	34	100,0

X^2=3.579, p=0.059

Education levels of substance dependents and control group groups were compared with chi- square analysis and no significant difference was found. According to the findings, 13 (38.2%) participants were graduated from primary school, 21 (61.8%) were graduated from middle school, high school and university in Dependent Group. In control group 6 (17.6%) participants were graduated from primary school, 28 (82.4%) were graduated from middle school, high school and university in Control Group.

Table 12.

Comparison of working in substance dependents and control group

	Substance Dependents		Control Group	
	n	%	n	%
Have job	18	52.9	23	67,6
No job	16	47.1	11	32,4
Total	34	100,0	34	100,0

X^2=1.536, p=0.215

Our results showed that, 18 (52.9%) participants have job and 16 (47.1%) participants have no job in Substance Dependent Group. 23 (67.6%) participants have job and 11 (32.4%) participants have no job in Control Group.

Table 13.

Comparison of monthly income level of substance dependents and control group

	Substance Dependents		Control Group	
	n	%	n	%
1000 TL and low	16	47.1	10	29.4
1600TL-5000TL	18	52.9	24	70.6
Total	34	100	34	100

X^2=2.242, p=0.134

Monthly income of substance dependents and control group groups were compared with chi- square analysis, no significant difference was found. In substance dependents group, 16 (47.1%) participants had 1000TL and low monthly income, 18 (52.9%)

participants had 1600TL-5000TL. In control group, 10 (29.4%) participants had 1000TL and low monthly income, 24 (70.6%) participants had 1600TL-5000TL monthly income.

4.3. Comparison of Childhood Trauma Between Substance Dependents and Non-Dependents

Table 14.

The comparison of total mean scores of CTQ between substance dependent and control groups

Childhood Trauma	*n*	$\bar{X}$	*sd*	*t*	*df*	*p*
Substance Dependent group	34	52.97	11.46	3.90	66	0.000**
Control group	34	44.41	5.65			

*p ≤0.05, **p <0.001, N=number, $\bar{X}$=Mean, sd=standard deviation

We compared the mean score of Childhood trauma scale between substance dependents and control group by Independent sample t-test. We found that there was a significant difference between substance dependents and control group. When total mean scores of CTQ is compared between patient and control group with t-test analysis, the patient group was found to have significantly higher scores (t=3.90, df=66, p=0,000).

Table 15.

The comparison of mean scores of emotional abuse subscale of CTQ between substance dependent and control groups

Emotional abuse	*n*	$\bar{\bar{X}}$	*sd*	*T*	*df*	*p*
Substance Dependent group	34	8.62	4.04	2.87	66	0.006*
Control group	34	6.29	2.44			

*p ≤0.05, **p <0.001

The mean score of emotional abuse compared between substance dependents and control group by Independent sample t-test. It was found that there was a significant difference them (t=2.87, df=66, p=0,006).

Table 16.

The comparison of mean scores of physical abuse subscale of CTQ between substance dependent and control groups

Physical abuse	*n*	$\bar{\bar{X}}$	*sd*	*t*	*df*	*p*
Substance Dependent group	34	8,29	4,19	3,97	66	0,000**
Control group	34	5,29	1,38			

*p ≤0.05, **p <0.001

When physical abuse subscale compared between substance dependents and control group by Independent sample t-test, it was found that there was a significant difference (t=3.97, df=66, p=0,000).

Table 17.

The comparison of mean scores of physical neglect subscale of CTQ between substance dependent and control groups

Physical neglect	*n*	$\bar{\bar{X}}$	*sd*	*t*	*df*	*p*
Substance Dependent group	34	10,18	2,27	0,87	66	0,383
Control group	34	9,76	1,52			

*p ≤0.05, **p <0.001

We compared the mean score of physical neglect between substance dependents and control group by Independent sample t-test. We found that there was not any significant difference between them (t=0.87, df=66, p=0.383).

Table 18.

The comparison of emotional neglect subscale of CTQ between substance dependent and control groups

Emotional neglect	*n*	$\bar{\bar{X}}$	*sd*	*t*	*df*	*p*
Substance Dependent group	34	12,09	4,94	1,98	66	0,05
Control group	34	10,09	3,18			

*p ≤0.05, **p <0.001

When the mean score of emotional neglect subscale *of CTQ* is compared between substance dependents and control group by Independent sample t-test, it was found that there was a significant difference between substance dependents and control group (t=1.98, df=66, p=0.05).

Table 19.

The comparison of sexual abuse subscale of CTQ between substance dependent and control group

Sexual abuse	*n*	$\bar{\bar{X}}$	*sd*	*t*	*df*	*p*
Substance Dependent group	34	5,56	1.33	1,48	66	0.146
Control group	34	5.18	0,72			

*p ≤0.05, **p <0.001

The mean score of sexual abuse subscale *of CTQ is* compared between substance dependents and control group by Independent sample t-test. It was found that there was not any significant difference between them (t=1.48, df=66, p=0.146).

4.4. Comparison of Psychological Symptoms of Substance Dependents and Non-Dependents

Table 20.

The comparison of depression subscale of BSI between substance dependent and control group

Depression	*n*	$\bar{X}$	*sd*	*t*	*df*	*p*
Substance Dependent group	34	25,32	10,99	7,33	65	0.000
Control group	34	7,48	8,76			

*p ≤0.05, **p <0.001

In the present study the mean score of Depression was compared between substance dependents and control group by Independent sample t-test. It was found that there was a significant difference between substance dependents and control group (t=7.33, df=65, p=0,000).

Table 21.

The comparison of anxiety subscale of bsi between substance dependent and control group

Anxiety	*n*	$\bar{X}$	*sd*	*t*	*df*	*P*
Substance Dependent group	34	19,85	8,59	6,80	66	0.000
Control group	34	6,23	7,90			

*p ≤0.05, **p <0.001

When the mean score of anxiety compared between substance dependents and control group by Independent sample t-test, it was found that there was a significant difference between substance dependents and control group (t=6.80, df=66, p=0,000).

Table 22.

The comparison of somatisation subscale of bsi between substance dependent and control group

Somatisation	*n*	$\bar{X}$	*sd*	*t*	*df*	*p*
Substance Dependent group	34	12.47	6.91	5,85	66	0.000
Control group	34	3,91	4,99			

*p ≤0.05, **p <0.001

We compared the mean score of somatisation between substance dependents and control groups by Independent sample t-test. We found that there was a significant difference between substance dependents and control group (t=5.85, df=66, p=0,000).

Table 23.

The comparison of self negativity subscale of BSI between substance dependent and control group

Self negativity	*n*	$\bar{X}$	*Sd*	*t*	*df*	*p*
Substance Dependent group	34	20,12	10,31	6,44	66	0.000
Control group	34	6,35	6,99			

*p ≤0.05, **p <0.001

The mean score of self negativity subscale was compared between substance dependents and control groups by Independent sample t-test. It was found that there was a significant difference between substance dependents and control group (t=6.44, df=66, p=0.000).

Table 24.

The comparison of hostility subscale of bsi between substance dependent and control group

Hostility	*n*	$\bar{X}$	*sd*	*t*	*df*	*p*
Substance Dependent group	34	13,18	5,93	5,72	66	0.000
Control group	34	5,50	5,11			

*p ≤0.05, **p <0.001

We compared the mean score of hostility between substance dependent and control group by Independent sample t-test. We found that there was a significant difference between substance dependent and control group (t=5.72, df=66, p=0.000).

4.5. Comparison of PTSD And Substance Dependence and Non-Dependents

Table 25.

The comparison of PTSD between substance dependent and control group

PTSD	*N*	$\bar{X}$	*sd*	*t*	*df*	*p*
Substance Dependent group	34	54,18	1057	9,04	66	0.000
Control group	34	30,23	11,26			

*p ≤0.05, **p <0.001

The mean score of PTSD was compared between substance dependents and control groups by Independent sample t-test. It was found that there was a significant difference between them (t=9.04, df=66, p=0,000).

Table 26.

The correlation between API, BSI and PTSD subscales among substance dependent patients.

	API Total	API-Motivation to quit	Craving	Negative Life effects
BSI-Anxiety	r= 0.242 p= 0.168 n= 34	r= -0.106 p= 0.551 n= 34	r= 0.326 p= 0.060 n= 34	r= 0.181 p= 0.307 n= 34
Depression	r= 0.170 p= 0.336 n= 34	r= -0.024 p= 0.891 n= 34	r= 0.216 p= 0.221 n= 34	r= 0.190 p= 0.281 n= 34
Self Negativity	r= 0.312 p= 0.073 n= 34	r= -0.075 p= 0.674 n= 34	r= 0.323 p= 0.062 n= 34	r= 0.298 p= 0.087 n= 34
Somatization	r= 0.431* p= 0.011 n= 34	r= -0.028 p= 0.877 n= 34	r= 0.483** p= 0.004 n= 34	r= 0.414* p= 0.015 n= 34
Hostility	r= 0.307 p= 0.077 n= 34	r= -0.147 p= 0.406 n= 34	r= 0.380* p= 0.027 n= 34	r= 0.275 p= 0.115 n= 34
BSI Total	r= 0.322 p= 0.063 n= 34	r= -0.081 p= 0.649 n= 34	r= 0.379* p= 0.027 n= 34	r= 0.302 p= 0.083 n= 34
PTSD	r= 0.504** p= 0.002 n= 34	r= 0.021 p= 0.905 n= 34	r= 0.479** p= 0.004 n= 34	r= 0.413* p= 0.015 n= 34

The Pearson Correlation statistical method was used to evaluate correlation between the API, PTSD and BSI subscales. According to the results, there was a positive relation between the somatisation and API total. Also there was a positive relation between somatisation and craving. But there wasn't any relation between depression, anxiety and craving. Somatisation and negative life effects were positive correlation. Hostility and

craving were positive relations. Findings showed that, there was a positive correlation between BSI and craving. There was also positive correlation between PTSD and API. PTSD and craving had positive relation. In addition there was a positive correlation between PTSD and negative life effects.

5. DISCUSSION

This study showed that substance dependent patients have more childhood abuse or neglect history, Post Traumatic Stress Disorder and psychological symptoms compared with non dependent people. Substance Dependence is described as a maladaptive pattern of substance use leading to clinically significant impairment or distress in DSM-IV (American Psychiatric Association, 2001). Substances have effects on central nervous system and changes people's psychological life, feelings, thoughts, behaviors and because of the chemical structure develop dependency in a short and easily way (Köknel, 1998). Problems with starting substance use have negative impact on social relationships and functionality (Ögel, 2007). Substance dependence is severely damaging the patient, destroys the life and has negative effects on social life. People's unsuccessful attempts to solve their problem take them into addiction world. Substance dependents have self-destructive tendency. People avoid facing up to struggle to obtain drugs and these give them temporary gratification (Nyswander, 1956). Substance dependence is associated with many psychological factors and psychiatric disorders. In addition, mood disorders and anxiety disorders frequently occur in substance dependents (Arı, 2007).

This study showed that, there was a relationship between substance dependents and childhood trauma. This relation can be both ways. People who were abused in their childhood can treat themselves with using drugs. Beside this, using drugs at early ages can lead to abuse. Similarly with our result, past study showed that; if the individual had a history of emotional abuse and neglect in their childhood, they show self-mutilating behaviour and use substances (Karagöz, 2010). Childhood abuse was a risk factor for psychiatric disorders and substance dependence. In literature, it is mentioned that the

person which had child abuse, substance abuse occurs in later (Ekinci, Kandemir, 2015 & Çakıcı et al. 2000). Dunn and friends (1994) reported that 34% of substance dependents had childhood trauma history (as cited in Ögel, 2010). In a survey, that conducted in Turkey and TRNC 65% of substance use people had physical abuse in their childhood (Evren, Ögel, Tamar, & Çakmak, 2001). People with exposure to violence, low family support and childhood abuse history were major risk factors on substance dependence. People use substances as a way to deal with these problems (Şenyaşar, Kasap, & Aksoy, 2014). According to Jaffe (2002), people with childhood abuse and neglect history were more frequently use substance, depending to lack of impulse control. People use substances because of an object that gives pleasure and sedative for those who cannot control their impulse. Drugs and stimulants satisfy the needs emotional nutrition and suppressing painful and dissatisfied feelings (as cited in Ögel, 2010)

In the present study there was a relationship between substance dependents and PTSD. Similarly, in past study showed that PTSD increases the substance use (Epstein, Saunders, Kilpatrick, & Resnick, 1998). In another past study conducted with adolescents showed that substance dependent adolescents had more traumatic history compare to non-dependent adolescents (Perkonigg, Kessler, Storz, & Wittchen, 2000). Meisler (1996) defined that PTSD was prevalent in alcohol and substance users. The research that conducted in Turkey reported that, the rate of PTSD on substance dependent patients was 31%. Dependents which had PTSD showed that depression additional diagnosis was frequently seen in substance dependents (Kural, Evren, Can, & Çakmak, 2004). There was a probability of people developed substance abuse first and they enter into the dangerous situations, take risks and consequently exposed to several physical and

psychological trauma. They enter these risks again and again to reach substances and they develop PTSD. Consequently PTSD increases the substance use (Brady, Dansky, Sonne, & Saladin, 1998). Self medication theory defend that people develop substance dependency to cope with their symptoms of associated with PTSD and traumatic stress symptoms. According to substance dependents, alcohol, cannabis, opioid and benzodiazepines like substances have certain recovery (Jacobsen, Southwick, & Kosten, 2001). Past studies showed that PTSD can make difficult to stop substance because of the reminders of the traumatic event (Saladin, et al., 2003 & Coffey, et al., 2002). People avoid their negative feelings with using alcohol and substances (NCTSN, 2008).

In this study, substance dependent patients had more psychological symptoms compare to non dependent people. Consistent with this result, Evren and Ögel (2003) found a relation between substance dependents and anxiety. Past study showed that anxiety disorder and depression were seen in Substance Dependents (Kural et al., 2004). It is known that patients with depression use substances with the aim of self-treatment with the intention of medicine (self-medication) frequently (Ögel, 2010). According to Self Medication Hypothesis, people with psychiatric disorders use substances with the aim of to cope with their problems and in time they develop dependency (Dalbudak, 2008). According to the literature, low problem solving skill people have more psychological symptoms and they are more disposed to use substances (Arı, 2007). It has been suggested that substances such as alcohol and opioids can temporarily stop anxiety symptoms (Bozkurt, Pektaş, Kalyoncu, Mırsal, & Beyazyürek, 2003). Thoits (1994) reported that, problems had effect on the level of substance usage. Especially people who cannot solve their family and social problems and low problem skill people had more

psychological symptoms and had more predisposition to use substances. Stear (1977), defined heroin as a medication which substance dependents take it to control their depression and hostility feelings. The rate of depression on heroin dependents was between 25% and 33% (as cited in. Steer, Emery & Beck, 1980).

CONCLUSION AND RECOMMENDATIONS

This study showed that substance dependent patients have more childhood abuse or neglect history, Post Traumatic Stress Disorder and psychological symptoms compared with non-dependent people. The results of this study are highly consistent with the literature.

This study has some limitations. The major limitation of the present study is small number of participants and only male substance dependents participated in our study. These prevent the generalizability of the results to all TRNC population and another countries.

The other major limitation is Substance Dependent group was restricted to only treatment population and results can not possible to generalized non-treatment populations.

In different age groups and education levels can show different outcomes. Therefore, it is not possible to generalize the results to non-treatment population and it prevents the generalizability of the results for TRNC and another countries.

Childhood trauma questionnaire scale is also considered as limitation because of the retrospective self-report assessment of past experiences. Participants may respond in a different manner with aim of tended to be more different. The reliability of the scale filled without clinician intervention is lower than the structured form.

This study underlines the importance of child maltreatment history should always be examined in Substance Dependent patients. Childhood maltreatment is prevalent, and it has many consequences in adulthood. Our research showed that the risk of history of childhood trauma and PTSD on Substance Dependency. Our results showed that prevention programs should start at early stage of childhood and should give psycho-educational programs to both parents and children. In terms of social mental health, media, educators and health professionals have various tasks for the purpose of informing the people about substance dependency. In TRNC there is no private treatment and rehabilitation centre for alcohol/substance dependents. There should be established inpatient treatment and rehabilitation centre for alcohol/substance abuse in TRNC.

Finally, when all of these informations are considered, this research in our country provides important preliminary results for developing psycho-educational and psychosocial treatment programs for people, family and children about dependency. It is devoted to a number of recommendations in line with survey results. Childhood trauma known that may cause psychopathology in later stage of life. There should be making efforts to prevent trauma experienced in childhood and raising awareness of the family may be useful to raise public awareness.

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Appendix A. Informed Consent Form

AYDINLATILMIŞ ONAM

Bu çalışma Yakın Doğu Üniversitesi, Sosyal Bilimler Enstitüsü Klinik Psikoloji Ana Bilim Dalı - Yüksek Lisans Programı öğrencisi Feriha Çelik (20142418) tarafından, Prof. Dr. Mehmet ÇAKICI' nın danışmanlığında yürütülen bir tez çalışmasıdır.

Bu çalışmanın amacı KKTC'deki madde bağımlıları ile herhangi bir madde bağımlılığı olmayan bireylerin Travma Sonrası Stres Bozukluğu, Çocukluk Çağı Travmaları ve çeşitli psikolojik belirtiler açısından karşılaştırılmasıdır.

Çalışmaya katılım tamamen gönüllülük esasına dayanmaktadır. Anket tamamen bilimsel amaçlarla düzenlenmiştir. Anket formunda kimlik bilgileriniz yer almayacaktır. Size ait bilgiler kesinlikle gizli tutulacaktır. Çalışmadan elde edilen veriler yalnızca statistik veri olarak kullanılacaktır. Yanıtlarınızı içten ve doğru olarak vermeniz bu anket sonuçlarının toplum için yararlı bir bilgi olarak kullanılmasını sağlayacaktır.

Yardımınız için teşekkür ederim.

Psikolog,
Feriha Çelik.

Yukardaki bilgileri ayrıntılı biçimde tümünü okudum istediğim zaman yarıda kesip çıkabileceğimi biliyorum ve gönüllü olarak anketlerin uygulanmasını kabul ediyorum.

İsim:

İmza:

BİLGİLENDİRME FORMU

Madde Bağımlılığı Tanısı Olan ve Olmayan Bireylerin Çocukluk Çağı Travmaları ve Çeşitli Psikolojik Belirtiler Açısından Karşılaştırılması

Bu çalışmanın amacı KKTC'deki madde bağımlıları ile herhangi bir madde bağımlılığı olmayan bireylerin Travma Sonrası Stres Bozukluğu, Çocukluk Çağı Travmaları ve çeşitli psikolojik belirtiler açısından karşılaştırılmasıdır.

Bu çalışmada size bir demografik bilgi formu ve bir dizi ölçek sunduk. Demografik bilgi formu sizin yaş cinsiyet gibi demografik özellikleriniz hakkındaki soruları içermektedir. Ölçekler ise madde bağımlılığı, erken dönem travma yaşantıları ve çeşitli psikolojik belirtileri ölçmektedir.

Daha önce de belirtildiği gibi, ölçeklerde ve görüşmelerde verdiğiniz cevaplar kesinlikle gizli kalacaktır. Eğer çalışmanın sonuçlarını öğrenmek ya da araştırma hakkında daha fazla bilgi almak istiyorsanız aşağıdaki iletişim bilgilerinden araştırmacıya ulaşmaktan çekinmeyiniz.

Katıldığınız için tekrar teşekkür ederim.

Psikolog,

Feriha Çelik

Psikoloji Bölümü,

Yakın Doğu Üniversitesi,

Lefkoşa.

e-posta: ferihacelik@yahoo.com

Appendix B. Demographic Information Form

1. Cinsiyetiniz?

Kadın ☐ Erkek ☐

2. Yaşınız? (……)

3. Uyruğunuz nedir?

Kıbrıs ☐ Türkiye ☐ İngiltere ☐ Diğer ☐

4. Nerede yaşıyorsunuz? (….....……)

5. Eğitiminiz?

Okur yazar ☐ ilkokul mezunu ☐ Ortaokul mezunu ☐ Lise mezunu ☐ Üniversite mezunu☐

6. Medeni haliniz?

Bekar ☐ Nişanlı ☐ Evli ☐ Boşanmış ☐ Dul ☐ Ayrı ☐

7. Kiminle ve/veya kimlerle birlikte yaşıyorsunuz? (Birden fazla seçenek işaretleyebilirsiniz)

a. Yalnız	☐	d. Annem – babamla	☐
b. Eşimle	☐	e. Akrabalarla	☐
c. Çocuklarımla	☐	f. Arkadaşlarımla	☐

8. Size gelir getiren bir işte çalışıyor musunuz?

Evet çalışıyorum ☐ Hayır çalışmıyorum ☐

9. Aylık geliriniz yaklaşık ne kadardır?

Kendine ait geliri yok ☐
1000 TL ve altı ☐
1600 TL ve 5000 TL ☐
5000TL ve üzeri ☐

10. Daha önce herhangi bir psikiyatrik veya psikolojik tedavi gördünüz mü?

Evet ☐ Hayır ☐

11. Daha önce herhangi bir uyuşturucu madde kullandığınız oldu mu?

Evet ☐ Hayır ☐
(bu soruya hayır cevabını verdiyseniz, 12. Soruyu ve arka sayfadaki ilk 37 soruluk ölçeği cevaplamayınız)

12. Son bir yıl içinde Bonzai kullanıp kullanmadığınızı veya ne sıklıkla kullandığınızı belirtiniz.

Hiç ☐ Sadece bir iki kez ☐ Ayda 1-3 kere ☐ Haftada 1-5 kez ☐ Hemen hemen her gün ☐

Appendix C. Addiction Profile Index

BAĞIMLILIK PROFİL İNDEKSİ

Son bir yıl içinde aşağıdaki maddeleri kullanıp kullanmadığınızı veya ne sıklıkta kullandığınızı belirtiniz

Son bir yıl içinde…	Hiç	Sadece bir iki kez	Ayda 1-3 kere	Haftada 1-5 kez	Hemen hemen her gün
1.Alkol	☐	☐	☐	☐	☐
2.Esrar (marihuana, joint, gubar vb)……	☐	☐	☐	☐	☐
3.Ecstasy (Ekstazi)	☐	☐	☐	☐	☐
4.Eroin …….	☐	☐	☐	☐	☐
5.Kokain ……..	☐	☐	☐	☐	☐
6.Taş (krak kokain)……..	☐	☐	☐	☐	☐
7.Rohipnol, rivotril (roş) gibi haplar……...	☐	☐	☐	☐	☐
8.Uçucu maddeler (tiner, bali, gaz vb)…..……	☐	☐	☐	☐	☐
9.Çeşitli haplar (akineton, tantum, xanax vb)….	☐	☐	☐	☐	☐
10.Amfetamin türevleri (metamfetamin, ice vb)..	☐	☐	☐	☐	☐
11.Diğer (LSD, GHB vb)…….....	☐	☐	☐	☐	☐

Dikkat! Aşağıdaki sorularda yer alan [madde] sözcüğü son dönem içinde kullanmayı daha çok tercih ettiğiniz maddeyi anlatmaktadır. Bu nedenle temel olarak kullandığınız madde neyse, sorularda onu [madde] sözcüğü yerine koyunuz.

Örneğin… "[Madde] kullanmak aile ilişkilerimi olumsuz yönde etkiledi" yerine alkol içiyorsanız "Alkol kullanmak aile ilişkilerimi olumsuz yönde etkiledi" veya esrar içiyorsanız "Esrar kullanmak aile ilişkilerimi olumsuz yönde etkiledi" biçiminde okuyun.

12.[Madde] etkisinde olduğunuz zamanlarda, ne sıklıkta problem yaşıyorsunuz? (örneğin film kopması, aşırı doz alma, kontrol kaybı vb)
□ Hiçbir zaman □ Nadiren □ Bazen □ Çoğu zaman □ Neredeyse her zaman

VIII.[Madde] kullanmanın sizin için bir sorun olduğunu düşünüyor musunuz, eğer düşünüyorsanız, ne kadar zamandır?
□ Benim için sorun değil □ 1 yıldan az □ 1-2 yıldır □ 3-4 yıldır □ 5 yıl ve daha fazla

SON BİR YIL İÇİNDE aşağıdakilerin ne sıklıkta olduğunu belirtiniz

13.Kullandığınız [maddenin] miktarı zaman içinde giderek arttı mı?
(örneğin giderek daha fazla miktarda [madde] kullanmak)
□ Hiçbir zaman □ Nadiren □ Bazen □ Çoğu zaman □ Neredeyse her zaman

14.Her zamanki dozda kullanmanıza rağmen kullandığınız [maddenin] etkisinde azalma oldu mu? (örneğin her zamanki kadar [madde] kullandığınız halde sarhoş olmama veya kafanızın güzel olmaması)
□ Hiçbir zaman □ Nadiren □ Bazen □ Çoğu zaman □ Neredeyse her zaman

15.Kullandığınız [maddeyi] kestiğinizde veya azalttığınızda bazı sorunlar ortaya çıktı mı? (örneğin uykusuzluk, terleme, sinirlilik, huzursuzluk, titreme vb)
□ Hiçbir zaman □ Nadiren □ Bazen □ Çoğu zaman □ Neredeyse her zaman

16.Kullandığınız [maddeyi] kestiğinizde ortaya çıkabilecek sorunlardan çekindiğiniz için [madde] kullandığınız oldu mu?
□ Hiçbir zaman □ Nadiren □ Bazen □ Çoğu zaman □ Neredeyse her zaman

17.[Madde] kullanmaya başladıktan sonra, kullanmayı durdurmakta zorlanıyor musunuz? (örneğin az içmeyi düşünüp fazla içmek veya kısa süre kullanmayı planlayıp uzun süre kullanmak)
□ Hiçbir zaman □ Nadiren □ Bazen □ Çoğu zaman □ Neredeyse her zaman

18.Kullandığınız [maddeyi] bırakmayı veya azaltmayı isteyip bunu başaramadığınız oldu mu?
□ Hiçbir zaman □ Nadiren □ Bazen □ Çoğu zaman □ Neredeyse her zaman

19.[Maddeyi] aramak, kullanmak veya etkisinden kurtulmak için fazla zaman harcadığınız oldu mu? (örneğin [madde] bulmak, kullanmak veya etkisinden kurtulmak zamanınızın büyük bir kısmını kaplıyor mu?)
□ Hiçbir zaman □ Nadiren □ Bazen □ Çoğu zaman □ Neredeyse her zaman

20.[Madde] kullandığınız için hayatınızdaki başka etkinliklerden vazgeçtiğiniz oldu mu? (örneğin aile ziyaretleri, hobiler, sosyal ilişkiler vb)
 Hiçbir zaman Nadiren Bazen Çoğu zaman Neredeyse her zaman

SON BİR YIL İÇİNDE aşağıdakilerin ne sıklıkta olduğunu belirtiniz
21.[Madde] kullanmak aile ilişkilerinizi olumsuz yönde etkiledi mi?
 Hiçbir zaman Nadiren Bazen Çoğu zaman Neredeyse her zaman

22.[Madde] kullanmak eğitim/ iş hayatınızı olumsuz yönde etkiledi mi?
 Hiçbir zaman Nadiren Bazen Çoğu zaman Neredeyse her zaman

23.[Madde] kullanmak beden sağlığınızı olumsuz yönde etkiledi mi?
 Hiçbir zaman Nadiren Bazen Çoğu zaman Neredeyse her zaman

24.[Madde] kullanmak ruhsal sağlığınızı olumsuz yönde etkiledi mi?
 Hiçbir zaman Nadiren Bazen Çoğu zaman Neredeyse her zaman

25.[Madde] kullanmak sizi ekonomik açıdan olumsuz yönde etkiledi mi?
 Hiçbir zaman Nadiren Bazen Çoğu zaman Neredeyse her zaman

26.[Madde] kullanmak arkadaş veya diğer insanlarla olan ilişkilerinizi olumsuz yönde etkiledi mi?
 Hiçbir zaman Nadiren Bazen Çoğu zaman Neredeyse her zaman

27.[Madde] kullanmak başınızı derde soktu mu? (örneğin kavga, kaza, istenmeyen cinsel ilişki-gebelik, cinsel yolla bulaşan hastalık vb)
 Hiçbir zaman Nadiren Bazen Çoğu zaman Neredeyse her zaman

28.[Madde] kullanmak yasal sorunlar yaşamanıza neden oldu mu? (örneğin maddeyle yakalanmak, ehliyeti kaptırmak, karakola düşmek vb)
 Hiçbir zaman Nadiren Bazen Çoğu zaman Neredeyse her zaman

29 Gündüz saatlerinde de [madde] kullandığınız oldu mu?
 Hiçbir zaman Nadiren Bazen Çoğu zaman Neredeyse her zaman

30.[Madde] kullanmayı istememenize rağmen yine de gidip [madde] kullandığınız oldu mu?
 Hiçbir zaman Nadiren Bazen Çoğu zaman Neredeyse her zaman

31.Aileniz veya çevreniz sizin çok fazla [madde] kullandığınızdan endişeleniyor mu?
 Hiçbir zaman Nadiren Bazen Çoğu zaman Neredeyse her zaman

SON BİR HAFTA İÇİNDE aşağıdakilerin ne sıklıkta olduğunu belirtiniz

32.Ne sıklıkta aklınıza [madde] kullanmak ya da [maddenin] keyif verici/rahatlatıcı etkisi geliyor?

□ Hiçbir zaman □ Nadiren □ Bazen □ Çoğu zaman □ Neredeyse her zaman

33.Ne sıklıkta [madde] kullanmak için kuvvetli bir istek, arzu veya dürtü hissediyorsunuz?

□ Hiçbir zaman □ Nadiren □ Bazen □ Çoğu zaman □ Neredeyse her zaman

34.[Madde] ile karşılaştığınızda [madde] kullanmaya direnmek veya kullanmamak sizin için zor olur mu?

□ Hiçbir zaman □ Nadiren □ Bazen □ Çoğu zaman □ Neredeyse her zaman

35.[Madde] kullanmanın sizin için bir sorun olduğunu düşünüyor musunuz?

□ Hiçbir zaman □ Nadiren □ Bazen □ Çoğu zaman □ Neredeyse her zaman

36.[Madde] kullanmayı bırakmayı veya azaltmayı düşünüyor musunuz?

□ Hiçbir zaman □ Nadiren □ Bazen □ Çoğu zaman □ Neredeyse her zaman

37.[Madde] kullanmayı bırakmak veya azaltmak sizin için önemli mi?

□ Hiçbir zaman □ Nadiren □ Bazen □ Çoğu zaman □ Neredeyse her zaman

Appendix D. Childhood Trauma Questionnaire

ÇOCUKLUK ÇAĞI TRAVMALARI ÖLÇEĞİ

Bu sorular çocukluğunuzda ve ilk gençliğinizde (20 yaşından önce) başınıza gelmiş olabilecek bazı olaylar hakkındadır. Her bir soru için sizin durumunuza uyan rakamı daire içerisine alarak işaretleyiniz. Sorulardan bazıları özel yaşamınızla ilgilidir; Lütfen elinizden geldiğince sorulara gerçeğe uygun bir biçimde yanıt veriniz. Yanıtlarınız gizli tutulacaktır.

Çocukluğumda ya da ilk gençliğimde…

1.Evde yeterli yemek olmadığından aç kalırdım.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5.Çok Sık

2.Benim bakımımı ve güvenliğimi üstlenen birinin olduğunu biliyordum.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5.Çok Sık

3.Ailemdekiler bana "salak", "beceriksiz" ya da "tipsiz" gibi sıfatlarla seslenirlerdi.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5.Çok Sık

4.Anne ve babam ailelerine bakamayacak kadar sıklıkla sarhoş olur ya da uyuşturucu alırlardı.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5.Çok Sık

5.Ailemde önemli ve özel biri olduğum duygusunu hissetmeme yardımcı olan biri vardı.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5.Çok Sık

6.Yırtık, sökük ya da kirli giysiler içerisinde dolaşmak zorunda kalırdım.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5.Çok Sık

7.Sevildiğimi hissediyordum.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5.Çok Sık

8.Anne ve babamın benim doğmuş olmamı istemediklerini düşünüyordum.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5.Çok Sık

9.Ailemden birisi bana öyle kötü vurmuştu ki doktora ya da hastaneye gitmem gerekmişti.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5.Çok Sık

10.Ailemde başka türlü olmasını istediğim bir şey yoktu.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5.Çok Sık

11.Ailemdekiler bana o kadar şiddetle vuruyorlardı ki vücudumda morartı ya da sıyrıklar oluyordu.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5.Çok Sık

12.Kayış, sopa, kordon ya da başka sert bir cisimle vurularak cezalandırılıyordum.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5.Çok Sık

13.Ailemdekiler birbirlerine ilgi gösterirlerdi.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5.Çok Sık

14.Ailemdekiler bana kırıcı ya da saldırganca sözler söylerlerdi.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5.Çok Sık

15.Vücutça kötüye kullanılmış olduğuma (dövülme, itilip kakılma vb.) inanıyorum.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5.Çok Sık

16.Çocukluğum mükemmeldi.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5.Çok Sık

17.Bana o kadar kötü vuruluyor ya da dövülüyordum ki öğretmen, komşu ya da bir doktorun bunu farkettiği oluyordu.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5.Çok Sık

18.Ailemde birisi benden nefret ederdi.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5.Çok Sık

19.Ailemdekiler kendilerini birbirlerine yakın hissederlerdi.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5.Çok Sık

20.Birisi bana cinsel amaçla dokundu ya da kendisine dokunmamı istedi.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5.Çok Sık

21.Kendisi ile cinsel temas kurmadığım takdirde beni yaralamakla ya da benim hakkımda yalanlar söylemekle tehdit eden birisi vardı.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5.Çok Sık

22.Benim ailem dünyanın en iyisiydi.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5.Çok Sık

23.Birisi beni cinsel şeyler yapmaya ya da cinsel şeylere bakmaya zorladı.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5.Çok Sık

24.Birisi bana cinsel tacizde bulundu.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5.Çok Sık

25.Duygusal bakımdan kötüye kullanılmış olduğuma (hakaret, aşağılama vb.) inanıyorum.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5.Çok Sık

26.İhtiyacım olduğunda beni doktora götürecek birisi vardı.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5.Çok Sık

27.Cinsel bakımdan kötüye kullanılmış olduğuma inanıyorum.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5.Çok Sık

28.Ailem benim için bir güç ve destek kaynağı idi.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5.Çok Sık

Appendix E. PTSD Checlist - Civilian Version

Soru Listesi - Sivil Versiyonu

Yönerge: Aşağıda,stress veren olayların ardından bazı insanlarda ortaya çıkabilen yakınma ve sorunlar bulunmaktadır. Lütfen dikkatli biçimde okuyun ve son bir ay içinde bu sorunun size ne derecede rahatsız ettiğini belirtmek üzere uygun seçeneği işaretleyin.

1. Geçmişte yaşamış olduğunuz olumsuz ve zorlayıcı olayla ilişkili, rahatsız verecek şekilde tekrarlayarak zihninizde canlanan anılar, düşünceler ya da görüntüler oldu mu?
   1.Hiç 2. Çok az 3. Orta derecede 4. Oldukça fazla 5. Aşırı

2. Geçmişte yaşamış olduğunuz olumsuz ve zorlayıcı olayla ilişkili, rahatsız verecek şekilde tekrarlayan rüyalarınız var mı?
   1.Hiç 2. Çok az 3. Orta derecede 4. Oldukça fazla 5. Aşırı

3. Aniden geçmişte yaşadığınız olumsuz ve zorlayıcı olayı hatırlayarak sanki yeniden yaşıyorsunuz hissine kapıldığınız ve davrandığınız oluyor mu?
   1.Hiç 2. Çok az 3. Orta derecede 4. Oldukça fazla 5. Aşırı

4. Geçmişte yaşamış olduğunuz olumsuz ve zorlayıcı olayı hatırlatan konuşma ortam ve kişiler ve de duygular sizde mutsuzluk üzüntü ve altüst olma duygusu yaşatıyor mu?
   1.Hiç 2. Çok az 3. Orta derecede 4. Oldukça fazla 5. Aşırı

5. Geçmişte yaşamış olduğunuz olumsuz ve zorlayıcı olayı hatırlatan konuşma, ortam ve kişi ve benzeşen uyaranla karşılaştığınızda kalp çarpıntısı, terleme, nefes darlığı, terleme, uyuşma, ağrı vb. bedensel tepkileriniz ortaya çıkar mı?
   1.Hiç 2. Çok az 3. Orta derecede 4. Oldukça fazla 5. Aşırı

6. Geçmişte yaşamış olduğunuz olumsuz ve zorlayıcı olay hakkında konuşmaktan, düşünmekten kaçınır, olayı hatırlatan duygulardan uzak durur musunuz?
   1.Hiç 2. Çok az 3. Orta derecede 4. Oldukça fazla 5. Aşırı

7. Size geçmişte yaşamış olduğunuz olumsuz ve zorlayıcı olayı hatırlattığı için bazı kişilerden, ortamlardan ve eylemlerden kaçınır ve uzak duru musunuz?
   1.Hiç 2. Çok az 3. Orta derecede 4. Oldukça fazla 5. Aşırı

8. Geçmişte yaşamış olduğunuz olumsuz ve zorlayıcı olayın bazı bölümlerini hatırlamakta zorlanır mısınız? Olaylar arasında bağlantıları kurmada zorlandığınız boşluklar var mı?
   1.Hiç 2. Çok az 3. Orta derecede 4. Oldukça fazla 5. Aşırı

9. Eskiden hoşlanarak yapmakta olduğunuz etkinliklere olan ilginizi kaybettiniz mi?
   1.Hiç 2. Çok az 3. Orta derecede 4. Oldukça fazla 5. Aşırı

10. Kendinizi diğer insanlardan uzak ve ayrı hissediyor musunuz?
1.Hiç 2. Çok az 3. Orta derecede 4. Oldukça fazla 5. Aşırı

11. Kendinizi duygusal açıdan donuklaşmış, yakınlarına ve olaylara karşı sevinme, üzülme ve ağlama duygularınız uyuşmuş gibi hissettiğiniz oluyor mu?
1.Hiç 2. Çok az 3. Orta derecede 4. Oldukça fazla 5. Aşırı

12. Geleceği planlamanın anlamsız ve boş olduğunu hissediyor musunuz?
1.Hiç 2. Çok az 3. Orta derecede 4. Oldukça fazla 5. Aşırı

13. Uykuya dalma ve sürdürme güçlüğünüz var mı?
1.Hiç 2. Çok az 3. Orta derecede 4. Oldukça fazla 5. Aşırı

14. Kendinizin gergin, tahammülsüz, sinirli ve çabuk öfkelenen biri olduğunu hissediyor musunuz?
1.Hiç 2. Çok az 3. Orta derecede 4. Oldukça fazla 5. Aşırı

15. Dikkatinizi toparlamada ve sürdürmede bir güçlüğünüz olduğu mu?
1.Hiç 2. Çok az 3. Orta derecede 4. Oldukça fazla 5. Aşırı

16. Kendizini aşırı derecede gergin, her an olumsuz birşey olacağı hissi ile tetikte ve diken üstünde hissediyor musunuz?
1.Hiç 2. Çok az 3. Orta derecede 4. Oldukça fazla 5. Aşırı

17. Çevreden gelen uyarılara abartılı tepkiler gösterdiğiniz kolaylıkla irkildiğiniz ve sıçradığınız oluyor mu?
1.Hiç 2. Çok az 3. Orta derecede 4. Oldukça fazla 5. Aşırı

Appendix F. Brief Symptom Inventory

KISA SEMPTOM ENVANTERİ

Aşağıda, zaman zaman herkeste olabilecek yakınmaların ve sorunların listesi verilmiştir. Lütfen her bir durumu dikkatle okuyunuz. Sonra bu durumun bugünde dahil olmak üzere son bir ay içerisinde sizi ne ölçüde huzursuz ve tedirgin ettiğini uygun seçeneğin altına **çarpı işareti koyarak (X)** işaretleyin.

		Hiç yok	**Çok az var**	**Orta derece de var**	**Epeyce fazla var**	**Çok fazla var**
1	İçinizdeki sinirlilik ve titreme hali	0	1	2	3	4
2	Baygınlık, baş dönmesi	0	1	2	3	4
3	Bir başka kişinin sizin düşüncelerinizi kontrol edeceği fikri	0	1	2	3	4
4	Başınıza gelen sıkıntılardan dolayı başkalarının suçlu olduğu duygusu	0	1	2	3	4
5	Olayları hatırlamada güçlük	0	1	2	3	4
6	Çok kolayca kızıp öfkelenme	0	1	2	3	4
7	Göğüs (kalp) bölgesinde ağrılar	0	1	2	3	4
8	Meydanlık (açık) yerlerden korkma duygusu.	0	1	2	3	4
9	Yaşamınıza son verme düşüncesi.	0	1	2	3	4
10	İnsanların çoğuna güvenilemeyeceği hissi.	0	1	2	3	4
11	İştahta bozukluklar.	0	1	2	3	4
12	Hiçbir nedeni olmayan ani korkular.	0	1	2	3	4
13	Kontrol edemediğiniz duygu patlamaları.	0	1	2	3	4
14	Başka insanlarla beraberken bile yalnızlık hissetme.	0	1	2	3	4
15	İşleri bitirme konusunda kendini engellenmiş hissetme.	0	1	2	3	4
16	Yalnızlık hissetme.	0	1	2	3	4
17	Hüzünlü, kederli hissetme.	0	1	2	3	4
18	Hiçbir şeye ilgi duymamak.	0	1	2	3	4
19	Kendini ağlamaklı hissetme.	0	1	2	3	4
20	Kolayca incinebilme, kırılma.	0	1	2	3	4
21	İnsanların sizi sevmediğine, size kötü davrandığına inanma.	0	1	2	3	4
22	Kendini diğer insanlardan daha aşağı görmek.	0	1	2	3	4
23	Mide bozukluğu,bulantı.	0	1	2	3	4
24	Diğer insanların sizi gözlediği ya da hakkınızda konuştuğu duygusu.	0	1	2	3	4
25	Uykuya dalmada güçlük.	0	1	2	3	4
26	Yaptığınız şeyleri tekrar tekrar doğru mu diye kontrol etmek.	0	1	2	3	4

27	Karar vermede güçlükler.	0	1	2	3	4
28	Otobüs, tren, metro gibi umumi vasıtalarla seyahatlerden korkma.	0	1	2	3	4
29	Nefes darlığı, nefessiz kalma.	0	1	2	3	4
30	Sıcak, soğuk basmaları.	0	1	2	3	4
31	Sizi korkuttuğu için bazı eşya yer ya da etkinliklerden uzak kalmaya çalışmak.	0	1	2	3	4
32	Kafanızın/zihninizin bomboş kalması.	0	1	2	3	4
33	Bedeninizin bazı bölgelerinde uyuşmalar, karıncalanmalar.	0	1	2	3	4
34	Hatalarınız için cezalandırılmanız gerektiği düşüncesi.	0	1	2	3	4
35	Gelecekle ilgili umutsuzluk duyguları.	0	1	2	3	4
36	Dikkati bir şey üzerine toplamada güçlük.	0	1	2	3	4
37	Bedenin bazı bölgelerinde zayıflık, güçsüzlük hissi.	0	1	2	3	4
38	Kendini gergin ve tedirgin hissetme.	0	1	2	3	4
39	Ölme ve ölüm üzerine düşünceler.	0	1	2	3	4
40	Birini dövme, ona zarar verme yaralama isteği.	0	1	2	3	4
41	Bir şeyleri kırma ,dökme isteği.	0	1	2	3	4
42	Diğer insanların yanında iken yanlış bir şey yapmamaya çalışmak.	0	1	2	3	4
43	Kalabalıklardan rahatsızlık duymak.	0	1	2	3	4
44	Başka insanlara hiç yakınlık duymamak.	0	1	2	3	4
45	Dehşet ve panik nöbetleri.	0	1	2	3	4
46	Sık sık tartışmaya girmek.	0	1	2	3	4
47	Yalnız kalındığında sinirlilik hissetme.	0	1	2	3	4
48	Başarılarınıza rağmen diğer insanlardan yeterince takdir görmemek.	0	1	2	3	4
49	Kendini yerinde duramayacak kadar tedirginlik hissetmek.	0	1	2	3	4
50	Kendini değersiz görme duygusu.	0	1	2	3	4
51	Eğer izin verirseniz insanların sizi sömüreceği duygusu.	0	1	2	3	4
52	Suçluluk duyguları.	0	1	2	3	4
53	Aklınızda bir bozukluk olduğu fikri.	0	1	2	3	4

YAKIN DOĞU ÜNİVERSİTESİ FEN VE SOSYAL BİLİMLER BİLİMSEL ARAŞTIRMALAR DEĞERLENDİRME ETİK KURULU (YDÜBADEK)

ARAŞTIRMA PROJESİ DEĞERLENDİRME RAPORU

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Yakın Doğu Üniversitesi Sosyal Bilimler Fakültesi Psikoloji Bölümü öğretim üyelerinden Prof. Dr. Mehmet ÇAKICI'nın sorumlu araştırmacısı olduğu, YDU/ 2016-08 proje numaralı ve ***"A comparison of childhood trauma history and psychological symptoms among substance dependents and non-dependents"*** başlıklı proje önerisi kurulumuzca değerlendirilmiş olup, etik olarak uygun bulunmuştur.

1- Prof. Dr. Mehmet Çakıcı (BAŞKAN)

2- Prof. Dr. Mahmut Savaş (ÜYE)

3- Doç. Dr. Nesil F. Baytın (ÜYE)

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Yakın Doğu Üniversitesi Sosyal Bilimler Enstitüsü, Uygulamalı (Klinik) Yüksek Lisans Programı'nda öğrenim gören **Feriha Çelik**'in, **"Madde Bağımlılığı Tanısı Olan ve Olmayan Bireylerin Çocukluk Çağı Travmaları ve Çeşitli Psikolojik Belirtiler Açısından Karşılaştırılması"** konulu araştırmasını **Mart – Haziran 2016** tarihleri arasında çalışmasını kabul eden kişilere hizmetleri aksatmayacak şekilde uygulaması ve tez çalışmasının raporlarını yayınlanmadan önce Bakanlığımızla paylaşması kaydıyla uygun görülmüştür.

Bilgilerinizi ve gereğini saygı ile rica ederim.

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Feriha Çelik was born in Kyrenia, 1991. She graduated from 23 Nisan Primary School, Anafartalar High School and Bülent Ecevit Anatolian High School.

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