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État de Stress Post-traumatique Comorbide, Facteurs de Risque et de Protection parmi des Individus Itinérants en Traitement pour des Troubles Liés à l'Utilisation de Substances

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Résumé

Peu d'études explorent les fréquences de traumas et d'état de stress post-traumatique (ÉSPT) chez les itinérants, spécifiquement parmi ceux avec des troubles liés à l'utilisation de substances (TUS). L'objectif principal de cette étude était de mesurer les fréquences de trauma et d'ÉSPT parmi les usagers en traitement pour des TUS à Montréal. L'autre objectif était de vérifier les différences entre ceux ayant ou non un ÉSPT. 51 individus itinérants, 9 femmes et 42 hommes, ont constitué l'échantillon. L'âge moyen était de 46 ans (*SD* = 7.19). Les participants ont vécu en moyenne 4.24 (*SD* = 2.06) types de trauma. 49% de l'échantillon avaient potentiellement un diagnostic d'ÉSPT. La majorité avait: un parent alcoolique, vécu un trauma dans l'enfance et un soutien social faible. Les participants qui avaient potentiellement un diagnostic d'ÉSPT: avaient un parent alcoolique, vécurent un trauma dans l'enfance et utilisaient davantage de stratégies de *coping* inadaptées.

Mots-clés: Itinérance, Utilisation de substances, Trauma, ÉSPT, Alcoolisme parental, Soutien social, Stratégies de *coping*.

Abstract

Few studies explored the frequencies of trauma and of posttraumatic stress disorder (PTSD) among homeless individuals and especially, among those being treated for substance use disorders (SUD). The main objective of the study was to measure the frequencies of traumas and potential[1] PTSD diagnosis among clients being treated for SUD in Montreal. The other objective was to verify differences between those with or without a potential PTSD diagnosis. The sample consisted of 51 homeless individuals, 9 women and 42 men. The mean age was 46 years (*SD* = 7.19). Participants experienced in average 4.24 (*SD* = 2.06) trauma types. 49% of the sample had a potential PTSD diagnosis. Most participants had: an alcoholic parent, experience an early trauma and little social support. The participants who had a potential PTSD diagnosis: had an alcoholic parent, experienced an early trauma, and significantly used more maladaptive coping strategies.

Keywords: Homelessness, Substance use, Trauma, PTSD, Parental alcoholism, Social support, Coping strategies.

[1] The term potential is used since no diagnosis could be posed. Instruments were administered, but no clinical interviews based on the DSM-IV were conducted. Thus, it is preferable to remain prudent.

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Liste des abréviations

ÉSPT	État de Stress Post-traumatique
PTSD	Posttraumatic Stress Disorder
SUD	Substance use Disorders
TUS	Troubles Liés à l'Utilisation de Substances

Remerciements

Je tiens à remercier tous ceux qui m'ont soutenu du début à la fin de cet ouvrage. Il y a tout d'abord Louise Nadeau qui a été ma directrice de recherche, mais qui a aussi veillée à ce que je sois bien formé professionnellement tout en s'assurant de mon bien-être. Puis, il y a bien sûr ma mère, ma sœur, tout le reste de ma famille et mes amis qui m'ont toujours encouragé à continuer mes études. Il y a aussi une femme très importante dans ma vie qui m'a soutenu moralement du début à la fin, soit Janny Zheng. Il y aussi le Centre Dollard-Cormier, Institut universitaire sur les dépendances qui m'a permis de faire mon étude et qui m'a soutenu financièrement.

Introduction

Ce mémoire a pour objet une étude clinique auprès d'itinérants consultant pour des troubles liés à l'utilisation de substances (TUS). Le principal objectif de cette étude est l'évaluation des fréquences d'événements traumatiques et de diagnostics potentiels d'état de stress post-traumatique (ÉSPT) parmi ces personnes. Cet objectif répond à la fois à un besoin d'études sur le sujet, surtout au Canada, et à un besoin clinique de mieux intervenir auprès de cette clientèle.

L'introduction de ce mémoire décrit : ce qu'est l'itinérance, ses caractéristiques, sa prévalence, ses modèles explicatifs et ses facteurs de risque. Le diagnostic d'ÉSPT est ensuite expliqué, puis les associations entre les traumas, l'ÉSPT et l'itinérance sont décrites. Enfin, les objectifs de l'étude et les démarches préalables à la collecte de données sont présentés.

Le corps du texte qu'est l'article empirique suit l'introduction. Les taux de prévalence de l'ÉSPT aux niveaux populationnel, clinique et chez les itinérants sont présentés. Puis, les facteurs de protection et de risque associés à l'itinérance, les TUS et l'ÉSPT sont décrits, soit l'alcoolisme parental, les traumas dans l'enfance, le soutien social et les stratégies de *coping* [2]. Les questions de recherche sont ensuite présentées, suivies de la méthodologie, des résultats et de la discussion.

[2] Le terme *coping* est utilisé en tant que synonyme du terme adaptation dans ce texte.

Finalement, une conclusion suit l'article et permet de dégager les points importants de cette étude et de souligner les apports à la communauté scientifique. Suite aux résultats, des recommandations cliniques sont ensuite proposées.

Définition, prévalences et étiologie de l'itinérance

Un individu itinérant est défini, selon la Commission des affaires sociales du Gouvernement du Québec, comme un individu n'ayant pas d'adresse fixe, de logement stable, sécuritaire et salubre, qui a un très faible revenu, un accès discriminatoire aux services, des problèmes de santé physique, de santé mentale, de toxicomanie, de violence familiale et/ou de désorganisation sociale et qui est dépourvu d'appartenance sociale (Gouvernement du Québec, 2008). Selon l'étude de Tessler, Rosenheck & Gamache (2001), la majorité des itinérants sont des hommes d'une ethnie minoritaire, ayant 45 ans et moins, sans emploi, avec un diagnostic psychiatrique ou TUS et ayant vécu dans un foyer familial instable durant l'enfance. D'ailleurs, les hommes itinérants vivent davantage d'épisodes d'itinérance et demeurent itinérants plus longtemps que les femmes itinérantes (Grimm & Maldonado, 1995; Sumerlin, 1999). Il est estimé qu'entre 10 à 50 % des itinérants ont des TUS (Han, Lee, Ahn, Park, Cho & Hong 2003; Liberty, Johnson, Jainchill, Ryder, Messina, Reynolds & Hossain, 1998; Milby, Schumaker, Raczynski, Caldwell, Engle, Michael & Carr, 1996; Munoz, Vazquez, Bermejo, & Vazquez, 1999; Sacks, Drake, & Williams, 2003). Les troubles mentaux sévères et persistants sont aussi très fréquents chez les adultes itinérants : 20 à 25 % ont un diagnostic au cours des 12 derniers mois (Eynan, Langley, Tolomiczenko, Rhodes, Links, Wasylenki & Goering,

2002; Shern & al., 2000; Sullivan, Burnam, Koegel, & Hollenberg, 2000) , 70-80 % en ont un à vie (Velasquez, Crouch, von Sternberg & Grosdanis, 2000) et 53.4 % en ont plus de deux à vie (Fichter, Quadflieg, Greifenhagen, Koniarczyk & Wolz, 1997).

L'itinérance touche une quantité importante d'individus. Il est estimé, selon des mesures transversales, qu'il y a 3,5 millions (1 % de la population) d'itinérants aux États-Unis par année (Burt, Aron, Douglas, Valente, Lee, & Iwen, 1999), entre 150 000 à 300 000 (0,5-1% de la population) au Canada (Santé Canada, 2006) et 28 000 à Montréal, Québec (Chevalier & Fournier, 1997). Ces taux sont cependant sujets à changement puisque des individus sortent et entrent de l'itinérance selon des facteurs saisonniers et la disponibilité d'abris (Pankratz & Jackson, 1994). De plus, certains peuvent habiter dans des endroits temporaires avec des membres de leur famille ou des amis et, ainsi, ne pas être calculés dans les taux populationnels (Springer, 2000). Néanmoins, ces chiffres représentent une partie non négligeable de la population.

L'itinérance est donc un phénomène qui frappe une quantité importante d'individus. Plusieurs trajectoires mutuellement non exclusives peuvent y mener. L'étiologie de l'itinérance n'étant pas simple, il y a quelques modèles auxquels il est important de se référer (voir Kim & Ford, 2006). Selon le modèle de la stratification sociale, les individus deviennent progressivement itinérants, car ils n'obtiennent pas suffisamment de ressources (Sosin, 2003). Leurs compétences sociales et économiques pour l'obtention de ressources sont déficientes relativement à celles d'autres individus plus habiles. Selon le modèle de conservation des ressources, les individus, qui éprouvent des pertes de ressources dues à

des facteurs incontrôlables, vivent un stress important et deviennent moins aptes à conserver leurs ressources et/ou à les accéder (Monnier & Hobfoll, 2000). Ensuite, dans un mouvement de spirale, cela leur occasionne à nouveau un stress important qui amène à son tour d'autres pertes. Ce cycle se répète jusqu'à l'itinérance. Le modèle de la trajectoire intègre à la fois les deux modèles précédents et propose que l'itinérance est un épisode dans la vie d'un individu où des événements stressants et des difficultés financières, relationnelles, de santé mentale et physique cumulent, diminuent les capacités financières de l'individu et le rendent incapable de conserver et obtenir une résidence (Clapham, 2003). Les facteurs de risque associés à l'itinérance qui sont présentés dans la prochaine section peuvent s'insérer dans ces trois modèles.

Facteurs de risque de l'itinérance

La pauvreté constitue un facteur central à l'itinérance car elle est associée à des revenus insuffisants provenant d'un emploi souvent instable et à un faible niveau socioéconomique qui, pour sa part, est associé à un environnement plus limité au niveau du soutien financier et psychologique (Morrell-Bellai, Goering & Boydell, 2000). En fait, ne pas avoir un emploi stable ou une scolarité avancée limitent grandement les capacités financières d'un individu et sa capacité de faire face à des imprévus financiers, le rendant ainsi à risque d'être plus pauvre et ultimement itinérant (Morrell-Bellai & al., 2000). Puis, ne pas avoir accès à des réseaux sociaux assurant un soutien social adéquat en cas de problèmes financiers, psychologiques ou de santé constitue également un facteur de risque pour l'itinérance (Morrell-Bellai & al., 2000). De plus, les problèmes relationnels

constituent également des facteurs de risque importants de l'itinérance, que ce soit avec les membres de la famille ou les amis avec qui les personnes sont demeurées en contact (Snow & Anderson, 1993). Les problèmes les amenant progressivement vers l'itinérance débutent souvent dans l'enfance dans un milieu dysfonctionnel où l'alcoolisme parental, les abus, la maltraitance et la négligence sont fréquents (Cauce, 2000; Tyler & Cauce, 2002). Plusieurs itinérants sont victimes de négligence parentale et d'abus étant jeunes, fuient leur foyer à l'adolescence et sont victimes à nouveau à l'extérieur de leur foyer.

Il en est de même à l'âge adulte pour toutes les formes de maltraitance avant et durant l'itinérance (Bassuk, E.L., Buckner, Perloff & Bassuk, S.S., 1998; Ford & Frisman, 2002; Kim, Ford, Howard & Bradford, 2010; Terrell, 1997). De plus, un diagnostic psychiatrique ou des TUS peuvent amener ces personnes à devenir itinérants, endommager leurs réseaux sociaux, les empêcher de conserver un emploi ou leur bloquer l'accès à d'autres emplois (Snow & Anderson, 1993; Tessler & al., 2001). Par ailleurs, il est également possible que tous ces facteurs de risque soient aussi des conséquences de l'itinérance (Tessler & al., 2001).

Trauma et état de stress post-traumatique

Les événements traumatiques et le diagnostic d'état de stress post-traumatique (ÉSPT) sont également associés à l'itinérance en tant que facteurs de risque et conséquences (voir Kim & Ford, 2006 et Kim & al., 2010). Plus spécifiquement, des individus peuvent devenir itinérants car des événements traumatiques peuvent les amener à

être gravement blessés (blessures graves, traumatisme crânien, etc.), quitter leur emploi, perdre des êtres chers, altérer leur fonctionnement normal, développer des troubles de l'humeur, des troubles anxieux, des TUS et principalement, un ÉSPT.

Le diagnostic d'ÉSPT se développe pour un peu moins d'un tiers de ceux qui vivent un événement traumatique dans la population générale (Adshead, 2000). Les symptômes de l'ÉSPT se regroupent en catégories : la reviviscence (flashbacks, cauchemars, pensées intrusives), l'évitement (de sentiments, de pensées, de lieux, d'activités) et l'émoussement affectif (réduction d'intérêt pour les activités quotidiennes, affect plat, impression d'avenir bouché) et l'hyperactivation neurovégétative (vigilance accentuée, fortes réactions physiques, insomnie) (American Psychiatric Association, 1994). Par conséquent, un individu avec un diagnostic d'ÉSPT peut difficilement fonctionner normalement et est beaucoup plus à risque de perdre son emploi et le soutien qu'il obtient des membres de sa famille et de ses amis.

Il n'est donc pas surprenant qu'une grande majorité (de 80 % à 100 %) des itinérants obtenant des services auprès d'abris ou ayant des troubles mentaux et des TUS ont vécu des événements traumatiques au cours de leur vie et ce, encore plus chez les femmes (Buhrich, Hodder & Teesson, 2000; Christensen, Hodgkins, Garces, Estlund, Miller & Touchton, 2005; Gelberg & Linn, 1992; Taylor & Sharpe, 2008). Ainsi, 41 % des itinérants d'une étude ont développé un ÉSPT au cours de la dernière année et jusqu'à 79 % ont un diagnostic à vie d'ÉSPT (Taylor & Sharpe, 2008). De même, chez les itinérants ayant des TUS, 48 % ont vécu un événement traumatique au cours de la dernière année et

56,7 % ont développé un ÉSPT dans la même année (Larney, Conroy, Mills, Burns & Teesson, 2009).

Les événements traumatiques et leurs conséquences peuvent faciliter le passage d'un individu vers l'itinérance. Puis, les itinérants, vivant dans des milieux instables et n'ayant pratiquement aucune ressource, financière ou sociale, sont aussi plus à risque d'être exposés à des événements traumatiques. Les itinérants sont aussi un groupe particulièrement à risque d'éprouver des troubles mentaux. D'un autre côté, il existe peu d'écrits au sujet des fréquences d'événements traumatiques et de diagnostic d'ÉSPT chez les itinérants alors que ceux-ci peuvent être centraux dans leur trajectoire de vie. Bien qu'il existe des études auprès d'itinérants recrutés dans des refuges, il y a des lacunes au niveau de l'évaluation des fréquences d'événements traumatiques et d'ÉSPT parmi les itinérants activement en traitement pour des TUS. De plus, au Québec, voire même au Canada, trop peu d'études examinent la complexité du phénomène de l'itinérance.

Objectifs de l'étude et démarches

Constatant les besoins en recherche clinique, nous avons rencontré une équipe clinique spécialisée pour le traitement des TUS chez les itinérants. Il s'agit d'une unité clinique à Montréal faisant partie du Centre Dollard-Cormier, Institut universitaire sur les dépendances (CDC-IUD). Lors de la rencontre, nous avions pour but d'évaluer les besoins les plus urgents des cliniciens. Leurs principales inquiétudes concernaient l'observation de symptômes reliés au diagnostic d'ÉSPT parmi leurs usagers les plus difficiles. Or, il

n'existe aucune étude évaluant les fréquences d'événements traumatiques vécus et de diagnostic d'ÉSPT chez les itinérants au Canada.

Nous avons donc décidé de créer un projet servant principalement à l'évaluation de les fréquences des événements traumatiques et des symptômes de l'ÉSPT chez les itinérants en traitement pour des TUS pour pallier à la fois au manque de documentation scientifique sur le sujet et aux besoins cliniques de l'unité. Le projet fut soumis au département de psychologie de l'Université de Montréal et accepté. Ensuite, le certificat d'éthique au CDC-IUD fut obtenu. La collecte de données s'est déroulée en automne 2009 à l'unité clinique d'itinérance du CDC-IUD. Les analyses et les résultats font l'objet de l'article qui suit dans la prochaine section de ce mémoire.

Dans cet article, les fréquences d'événements traumatiques et de diagnostic d'ÉSPT ont été évaluées dans un échantillon de 51 usagers recrutés au sein de l'unité d'itinérance du CDC-IUD. Les différences au niveau des fréquences de traumas dans l'enfance, de l'alcoolisme parental, du soutien social perçu et de l'utilisation de stratégies de *coping*, entre ceux ayant potentiellement un diagnostic d'ÉSPT et ceux ne l'ayant pas ont été également vérifiées.

Contributions à l'article

J'ai procédé à la demande du certificat d'éthique au Comité d'éthique de recherche en toxicomanie. Puis, j'ai effectué la collecte de données. Ensuite, j'ai entré et analysé les données dans une base de données SPSS. J'ai écrit les premières versions de toutes les sections de l'article en suivant les normes de la 6e édition du manuel de l'APA. J'ai aussi écrit les versions subséquentes de l'article suite aux corrections, révisions et suggestions de Louise Nadeau.

Louise Nadeau, ma directrice de recherche et coauteur de l'article a effectué plusieurs révisions et m'a supervisé tout au long du projet de recherche.

Running head: TRAUMA, SUBSTANCE USE AND HOMELESSNESS

Co-occurring Posttraumatic Stress Disorder, Risk and Protective Factors among Homeless Individuals in Treatment for Substance-related Problems

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Abstract

Homeless individuals undergoing treatment for substance use disorders (SUD) can pose clinical challenges. Posttraumatic stress disorder (PTSD) symptoms have been observed in the most difficult clients, but no scientific literature documents this association in Canada. The study sample consisted of 51 homeless individuals, 9 women and 42 men, undergoing consultation for SUD in Montreal. The mean age was 46 years (*SD* = 7.19). Participants experienced on average 4.24 (*SD* = 2.06) trauma types, and 49% of the sample had a potential PTSD diagnosis. Most participants had the following characteristics: an alcoholic parent, a history of an early trauma and little social support. The participants with a potential PTSD diagnosis were significantly more likely to have had an alcoholic parent, to have experienced an early trauma and to use more maladaptive coping strategies.

Keywords: Homelessness, Substance use, Trauma, PTSD, Parental alcoholism, Social support, Coping strategies.

Co-occurring Posttraumatic Stress Disorder, Risk and Protective Factors among Homeless Individuals in Treatment for Substance-related Problems

Homeless individuals may be seen as disenfranchised from the rest of society. From the perspective of mental health and addiction workers, homeless persons represent complex cases; the patients often struggle with comorbidities and a personal history of child abuse and neglect. The staff of a program for homeless persons with substance use disorders (SUD) requested help because of the challenges involved in the clinical practice and because their most difficult clients showed symptoms associated with posttraumatic stress disorder (PTSD). At the time, there was no existing study in Montreal (province of Quebec) examining PTSD symptomatology among homeless persons undergoing treatment for SUD. As a result, this study was conducted. This paper focuses on homeless clients in treatment for SUD in an attempt to better understand co-occurring PTSD among these clients through examining risk factors and protective factors that may affect onset and outcomes.

Posttraumatic Stress Disorder

About 3.5% of the general United States population has had a PTSD diagnosis at any given time within the last year, and 6.8% has in their life so far (Kessler, Chiu, Demler & Walters, 2005; Kessler & al., 2005). Among adult users of treatment services for SUD,

the rate of PTSD is higher than for adults not using these services (for a review, see Ouimette & Brown, 2003). In a British study (Reynolds & al., 2005), 38.5 and 51.9% of an inpatient clinical population consulting for SUD met the criteria for a current and lifetime PTSD diagnosis, respectively. In a national Australian inquiry (Mills, Teesson, Ross & Peters, 2006), 34.4% of the population consulting for PTSD also had a co-occurring SUD. In several American clinical studies (Breslau, Davis, & Schultz, 2003; Jacobsen, Southwick & Kosten, 2001; Johnson, 2008), similar rates were reported. Among women in treatment for SUD, the PTSD rates are generally higher than for men and vary from 20 to 59% (Kessler, 2000; Najavits, Weiss & Shaw, 1997; Triffleman, Marmer, Delucci & Ronfield, 1995). In short, higher proportions of PTSD diagnoses are reported among clients in SUD treatment than among the general population.

Homelessness poses an additional risk for developing PTSD. The homeless, compared to other social categories, experience a higher rate of traumatic events (Gelberg & Linn, 1992). The Australian data are convincing: 90 to 98% (Buhrich, Hodder & Teesson, 2000; Taylor & Sharpe, 2008) of homeless adults report experiencing a traumatic event in their lifetime, with an average of six lifetime traumas; 41% of the sample had a PTSD diagnosis in the last 12 months, and 79% had one during their lifetime. Other studies indicate that 48% of homeless adults with SUD had experienced victimization in the past year, and 56.7% had current PTSD (Larney, Conroy, Mills, Burns & Teesson, 2009). In an American study, 79.5% of a sample of homeless adults suffering from both SUD and other mental illnesses had experienced a lifetime trauma (Christensen & al., 2005). Thus, a

conservative estimate of at least one-third of homeless clients of SUD services could have a potential PTSD disorder.

The association between the severity of SUD and the presence of PTSD among the homeless is not always linear. Homeless individuals in treatment for cocaine dependence who also have a PTSD diagnosis do not necessarily have more severe substance abuse problems than other homeless individuals undergoing the same treatment (Burns, Lehman, Milby, Wallace & Schumacher, 2010). Homeless men with a trauma history and homeless women with high PTSD symptomatology might have more mental health problems but do not necessarily have more severe substance abuse problems (Kim, Ford, Howard & Bradford, 2010; Schuster, 2008). These studies suggest that having PTSD does not directly correlate with the severity of substance abuse problems at any given time, even if one has SUD.

Several explanations exist for the high rate of co-occurrence of PTSD and SUD. One might be more psychologically or physiologically vulnerable to trauma due to previous chronic substance use or might develop SUD following trauma exposure. In addition, the presence of risk factors such as parental alcoholism and early trauma or, alternatively, the absence of protective factors such as availability of social support or coping strategies might also be involved (for a more detailed account, see Schäfer & Najavits, 2007).

Risk factors

Parental Alcoholism

Parental alcoholism and other SUD among adults treated for SUD and among the homeless are over-represented compared to the general population. For instance, 58.2% of a sample of clients from a public treatment center in Montreal declared having an alcoholic parent (Recherche et Intervention sur les substances psychoactives – Québec, 2003), and 46.8% of the homeless persons from a Montreal sample had at least one adult at home with SUD when they were younger (Fournier, 2001). Other studies with clinical samples show comparable rates of parental alcoholism (for a review, see Flora & Chassin, 2005). In contrast, in the general population of Canada and the United States, 12% and 11%, respectively, of children live in households with at least one parent with SUD (Statistics Canada, 1993; United States Department of Health and Human Services, 1999).

Parental alcoholism impacts children on multiple levels. In more vulnerable cases, it is associated with the onset and maintenance of alcohol dependence (Cloninger, Bohman & Sigvardsson, 1981; Goodwin, Schulsinger, Hermansen, Guze & Winokur, 1973; Kendler, Heath, Neale, Kessler & Eaves, 1992) and homelessness. As children, these persons might be exposed to low socioeconomic status, neurocognitive impairments due to poorly stimulating environments, exposure to violence in the home, parental and familial psychopathology, more general maladjustment and depressive symptomatology, modeling of drinking behavior and expectancies of positive alcohol effects (for a review, see Ellis, Zucker & Fitzgerald, 1997; see also Belliveau & Stoppard, 1995). In addition, parental alcoholism is related to childhood neglect, abuse, maltreatment, familial psychopathology and traumas (Walsh, MacMillan & Jamieson, 2003), all of which are pretrauma factors influencing the eventual development of a PTSD diagnosis (Koenen, 2006).

Early Trauma

Child abuse, both physical and sexual, is one of the strongest predictors of psychological problems in adulthood (Mian, Bala, & MacMillan, 2001). It is associated with anxiety and affective symptomatology severity, PTSD severity and a higher risk for lifetime PTSD (Bremner, Southwick, Johnson, Yehuda & Charney, 1993; Hasan, Ayhan, Özkan, Devran & Mansur, 2004; Widom 1999). When childhood trauma occurs in neglectful and abusive families, the trauma can be recurrent and complex, cause long-term problems and further expose an individual to trauma later in life (Cook & al., 2005).

Studies show that experiencing physical or sexual abuse and parental neglect during childhood are powerful risk factors for adult alcoholism and homelessness (Hasan & al., 2004; Herman, Susser, Struening, & Link, 1997). More specifically, parental alcoholism and neglect are associated with childhood abuse that, in turn, is related to chronic homelessness (Stein, Burden Leslie & Nyamathic, 2002) and is predictive of lifetime traumatic events and resultant PTSD (Bassuk, Dawson, Perloff & Weinreb, 2001; North & Smith, 1992). Not surprisingly, 69% of homeless women undergoing residential SUD treatment had experienced childhood abuses and fared worse in treatment compared to women who had not suffered abuse (Sacks, McKendrick & Banks, 2008). In sum, homeless individuals with SUD are more likely to have been exposed to both parental alcoholism and early trauma; these two risk factors are often associated with each other and with the presence and severity of PTSD.

Protective factors

While parental alcoholism and early trauma have significant effects on the life trajectory of an individual, not every individual who is exposed to these risk factors develops SUD and PTSD. Other mechanisms such as a lack of protective factors might better explain why the homeless are specifically more at risk for developing SUD and PTSD than other social categories. Social support and adaptive coping strategies are considered among those protective factors as they contribute to the resilience of a person facing stressors.

Social Support

Social support has been described as a key factor in mental health. Its presence is protective, and the lack of it constitutes a risk factor for conditions involving all forms of psychological distress. Lack of adequate social support in the general population has been shown to contribute to PTSD severity (Jovanovic, Aleksandric, Dunjic & Todorovic, 2004). Moreover, if clients in therapy for PTSD have access to adequate social support, their prognosis is better than those without (Billette, Guay, & Marchand, 2008; Monson, Rodriguez & Warner, 2005; Stein, Dixon & Nyamathi, 2008). Among women in psychotherapy who experienced interpersonal abuse (potentially traumatic events) and were diagnosed with mental health problems and SUD, those with more social support developed fewer symptoms following traumatic stress (Savage & Russell, 2005).

Considering the high level of psychological distress among the homeless population, it is unsurprising that social support deficits have been identified as contributing factors (for a review, see Nyamathi, Leake, Keenan & Gelberg, 2000). Indeed, several authors have correlated a lack of social support with the onset and chronicity of homelessness (Abdul-Hamid & Cooney, 1996; Herman, Susser, Jandorf, Lavelle, & Bromet, 1998; Morrell-Bellai, Goering & Boydell, 2000; Thompson, McManus & Voss, 2006). Moreover, a lack of adequate social support for the homeless is a contributing factor to the onset of SUD (Stein & al., 2008). Homeless individuals who perceived themselves as having access to social support were less likely to be victimized in the following 12 months, implying that those without such access are at a higher risk of victimization (Hwang & al., 2009). Thus, negative and traumatic childhood experiences, neglecting families and poor social support networks all act in synergy to lead to homelessness, SUD and poor mental health (Higgins, McCabe, & Ricciardelli, 2003; Morrell-Bellai & al., 2000). Accordingly, the majority of homeless individuals with SUD likely have less social support than the general population and those with a comorbid PTSD might have an even lower level of support.

Coping Strategies

Coping strategies for facing stress and symptoms are an important buffer of difficulties that individuals encounter. Like social support, coping is two-sided. On one hand, problem-focused coping, considered adaptive, constitutes a protective factor against

developing a PTSD following a traumatic event (Pedersen & Elkit, 1998; Sharkansky, King, D.W., King, L.A., Wolfe, Erickson & Stokes, 2000). On the other hand, use of "negative" coping strategies (for example, blaming oneself and others, wishful thinking and resignation) and avoidant coping strategies (for example, self-distraction, substance use, withdrawal from situations) to manage trauma are risk factors for PTSD (Berman, Kurtines, Silverman & Serafini, 1996; Stein & al., 2005). In addition, among female victims of domestic violence, those who have experienced more childhood traumatic events are more prone to use avoidant coping strategies and to fare worse than those who did not experience such events (Street, Gibson, Holohan, 2005).

The same situation applies to homeless individuals. Homeless adults of both genders and adolescent males who use "positive" coping strategies (for example, cognitive restructuring, problem solving, emotional regulation) have increased adaptive capacities: less substance use, more effective social skills for social reintegration, shorter homelessness durations, etc. (for a review, see Caton & al., 2005; and also Stein & al., 2008; Votta & Manion, 2003). The opposite is also true: the homeless individuals manifesting more adaptation problems have a higher risk for chronic and long-term homelessness (Caton & al., 2005). Among homeless women as well, those who have experienced childhood abuse are more prone to use avoidant coping (Rayburn, Wenzel, Elliot, Hambarsoomians, Marshall & Tucker, 2005). Equally, among homeless women who experienced a trauma and are in treatment for SUD, those with more substance use problems rely more on avoidant coping mechanisms (Stump & Smith, 2008). In addition, Schuster (2008) shows that homeless mothers using such strategies have more PTSD symptoms, whereas those

using more active coping strategies experience better posttraumatic growth. Thus, if coping strategies operate similarly for both the clinical populations and the homeless, those individuals with a PTSD disorder would more likely use maladaptive coping strategies and less likely adaptive coping strategies compared to those without such a disorder.

Objectives & Hypotheses

The literature evaluating PTSD rates among the homeless in treatment for SUD is scarce and, to our knowledge, non-existent in Canada. Considering the higher rates of PTSD among homeless populations from other countries than among the general population and the lack of scientific literature covering this subject in Canada, the objective of this study is to document the situation of the homeless in an urban sample, taking into account risk and protective factors identified in the literature. The first and main goal of this study was to examine the potential co-occurrence of PTSD in a sample of homeless individuals in treatment for SUD, and the second was to test associations with potential intervening variables. Seven variables were studied: potential PTSD, PTSD symptom severity, alcohol and drug problem severity, parental alcoholism, onset of trauma, perceived social support, and use of coping strategies. The study examined the whole sample characteristics and if the sub-group with potential PTSD (PTSD +), compared to the sub-group with no PTSD (PTSD-), will report the following:

1). no significant differences with: a) alcohol-related problems; and b) drug-related problems.

2). significant differences with: a) parental alcoholism; b) early trauma; c) social support; d) the frequency of use of adaptive coping strategies; and e) the frequency of use of maladaptive coping strategies.

Methods

Procedure

An ethics certificate was obtained, from the *Comité d'éthique de la recherche en toxicomanie,* and the study was initiated in agreement with the clinical team at a publicly funded treatment center in Montreal. During the year, 100 clients regularly attended the center, and from August to October 2009, clinicians informed them of the study. Those who gave written consent to participate met with the first author for a semi-structured interview of 75 minutes conducted in French. No exclusion criteria were used. Interviews were completed for every consenting participant.

Participants

Our sample consisted of 51 homeless persons, 9 women (17.65%) and 42 men (82.35%), consulting for SUD at a publicly funded treatment center in Montreal. The mean age was 46 years (*SD* = 7.19). The mean number of years of education was 11 years (*SD* = 4.72). Thirteen participants considered alcohol (25.5%) to be their main problem, 20 considered cocaine (39.2%) and 8 considered both alcohol and any other substance to be problematic (15.7%).

Measures

Abridged Research Version of the Addiction Severity Index. The validated French translation of this instrument was used (Bergeron, Landry, Brochu & Guyon, 1998; McLellan & al., 1992). It contains scales measuring the impacts of SUD on seven life spheres. Only the two scales concerning drug and alcohol use were used for this study. The severity score, varying from 0 to 1, for the last 30 days was used for both scales for this study since the lifetime score was unavailable. The higher the score, the more severe the problems were. Sociodemographic information, including questions to measure parental alcoholism, was also taken from this measure.

Trauma Assessment for Adults Self-Report. The validated French translation measure consisting of 14 yes/no questions was used (Resnick, Best, Kilpatrick, Freedy & Falsetti, 1993; Resnick, 1996; Stepheson & Brillon, 1995). This inventory inquires if the client experienced one or multiple traumatic events among frequently experienced types of trauma and, if so, when it was experienced for the first and last times (Criteria A of the DSM-IV PTSD diagnosis). A trauma experienced before 16 years of age was considered an early trauma.

Modified PTSD Symptom Scale Self-Report. The validated French translation of this instrument, consisting of 17 Likert-scale questions, was used (Guay, Marchand, Iucci & Martin, 2002; Falsetti, Resnick, Resick & Kilpatrick, 1993; Stepheson, Brillon, Marchand & Di Blasio, 1995). The scale was used to measure the intensity and frequency of symptoms of the criteria B, C and D of the DSM-IV PTSD diagnosis during the last two

weeks preceding the interview. The score varied from 0 to 119, with higher scores indicating more distress. A score of 50 and above indicated a highly probable PTSD diagnosis (less than 10% probability of committing a type 1 or type 2 error according to Guay & al., 2002), and participants with such scores were grouped in the subgroup PTSD +; participants with scores less than 50 were classified in the subgroup PTSD -. Importantly, this score is not the equivalent of a diagnosis after conducting a clinical interview such as the Clinician-Administered PTSD Scale.

Social Provisions Scale. The validated French translation of this 24-item measure, using scores varying from 1 to 4 on a Likert scale, was used (Caron, 1996; Caron, Tempier, Mercier, & Léouffre, 1998; Cutrona & Russel, 1987). The total score varied from 24 to 96, with higher scores indicating greater perceived social support. According to comparative data, a mean score of 77.88 (*SD* = 9.23) is judged to be the norm for the general population (Caron, 1996).

Brief COPE. The validated French translation of this 28-item Likert-scale instrument was used to assess coping strategies (Carver, 1997; Muller & Spitz, 2003). The items are divided into 14 coping dimensions (2 items each) that were inspired by Lazarus's work according to the authors. The total score of each dimension varies from 2 to 8. A score of 8 means the coping strategy is almost always used when facing stressful events, and a score of 2 means it is never used. The dispositional version of the instrument was used; it measured what an individual generally does when facing stress. The following seven dimensions were coping strategies that were used and considered adaptive: active coping, instrumental support, acceptance, positive reframing, emotional support, planning

and humor. The following five dimensions were coping strategies that were used and considered maladaptive: self-distraction, denial, behavioral disengagement, substance use and self-blame. The dimensions religion and venting were not used for this study as they were considered difficult to categorize as adaptive or not.

Statistical Analyses

To verify the frequency of potential PTSD, of parental alcoholism, of early trauma and the level of social support, descriptive analyses were performed. To verify differences between PTSD + and PTSD - with alcohol and drug-related problems, with parental alcoholism, with early trauma, with social support, with frequency of use of adaptive and of maladaptive coping strategies, intra-group comparisons were performed using t-tests. To verify differences between those with or without an alcoholic parent and between those who experienced or not an early trauma, t-tests were also performed.

Results

Characteristics of the whole sample

Every participant declared having experienced at least one potentially traumatic event during his or her lifetime. As indicated in Table 1, participants experienced on average 4.24 (*SD* = 2.06) trauma types out of a maximum of 13. The most frequent traumas were physical aggression with or without a weapon. The average score on the Modified PTSD Symptom Scale Self-Report was 52.25 (*SD* = 26.29), which is high considering that

a score of 50 is the threshold for a potential PTSD diagnosis. In fact, 25 participants (49%) scored above 50. Thus, the frequency of PTSD diagnosis was higher in this sample than in the general population (3.5%, last 12 months).

(insert Table 1 about here)

Forty participants (78.43%) had at least one alcoholic parent. Among those 40 participants, 72.5% had an alcoholic father and 33% had an alcoholic mother. Thirty-four participants (66.67%) declared having experienced a trauma before 16 years of age (early trauma). Out of the 34 homeless participants who experienced an early trauma, 31 also had an alcoholic father (83.78% of the total participants with alcoholic fathers), and 13 also had an alcoholic mother (76.47% of the total participants with alcoholic mothers). The sample had a mean score of 70.71 (*SD* = 13.40) on the EPS scale, meaning that the participants had a level of perceived social support below the norm of the general population. Thus, the majority of the sample declared having an alcoholic parent, experiencing an early trauma and having a lower social support than the general population.

Furthermore, as indicated in Table 2, those with an alcoholic parent, specifically a father, experienced significantly more early traumas and had more PTSD symptoms. In fact, 24 participants of the PTSD + group had an alcoholic parent. Those with an alcoholic parent also experienced significantly more early traumatic accidents and physical and sexual aggression. As indicated in Table 3, the participants who experienced an early trauma also had significantly more PTSD symptoms; 21 participants of the PTSD + group experienced an early trauma. They also experienced significantly more potentially traumatic events during their lifetime.

(insert Table 2 about here)

(insert Table 3 about here)

Factors influencing PTSD symptoms

As indicated in Table 4, the PTSD + group had significantly more problems with alcohol, but not with drugs. The PTSD + group significantly more often declared having an alcoholic parent, experienced an early trauma, and used most of maladaptive coping strategies (three out of five). There were no significant differences between groups in perceived social support or in the frequency of use of most adaptive coping strategies (three out of seven).

(insert Table 4 about here)

Discussion

This study proceeded to evaluate characteristics of homeless individuals seeking help for SUD and to verify multiple hypotheses pertaining to PTSD in such a group. All participants declared having experienced a potentially traumatic event during their lifetime, and as many as two-thirds experienced one before 16 years of age. These results are unsurprising considering the high rates of traumatic events previously found among the clients of SUD treatment centers (Ouimette & Brown, 2003) and among the homeless

(Buhrich & al., 2000; Christensen & al., 2005). Furthermore, half of the sample had sufficient symptomatology to indicate a potential PTSD, which is a high rate compared to the general population. In this sample, early traumatic events might have increased participants' vulnerability, which in turn contributed to their homeless status, and homelessness ultimately put them at risk for more traumatic events during their lifetime and for developing a PTSD (Bremner & al., 1993; Cook & al., 2005; Stein & al., 2002).

The participants in the PTSD + group did not have more problems with drugs than the PTSD - group, but they did have more problems with alcohol. Alcohol might be preferable to drugs to self-medicate PTSD symptoms (Schäfer & Najavits, 2007). Another explanation for this difference could be that chronic use of alcohol or peritraumatic intoxication might make one prone to develop traumatic symptomatology following exposure.

As in previous studies, most of the participants had an alcoholic parent, experienced at least one early trauma in their life and had a low level of social support; the adverse events were much more common among the subjects than among the general population (Abdul-Hamid & Cooney, 1996; Flora & Chassin, 2005; Fournier, 2001; Herman & al., 1997, 1998; Higgins & al., 2003; Morrell-Bellai & al., 2000; Nyamathi & al., 2000; Statistics Canada, 1993; Stein & al., 2008; Thompson, & al., 2006). Thus, for the whole sample, it appears that the most frequent clinical feature is an early trauma experienced by individuals with unstable home environments characterized by parental alcoholism and an unsupportive environment that does not counter the negative effects of the trauma. This feature is even more striking when measured only among participants in the PTSD + group because only one participant in that group did not have an alcoholic parent. This finding

further suggests that an alcoholic parent, especially a father, can be not only directly related to the traumatic experience of his child, but also indirectly contributing to it by putting his (or her) child in unsafe situations and by not providing significant support when such situations arise.

Contrary to findings in previous studies (Jovanovic & al., 2004; Monson & al., 2005; Billette & al., 2008; Stein & al., 2008), the participants in the PTSD + group did not perceive having less social support than the PTSD - group. It is likely that a lack or even an absence of social support is a conditional factor to the status of homelessness, as illustrated by the low level of social support at the sample level, and thus cannot account for any significant effect concerning traumas in particular.

Compared to the PTSD - group, the PTSD + group used most of the adaptive coping strategies equal, but used the maladaptive coping strategies more often. This result is inconsistent with the scientific literature pertaining to adaptive coping strategies, but consistent with it for maladaptive coping strategies (Berman & al., 1996; Caton & al., 2005; Pedersen & Elkit, 1998; Sharkansky & al., 2000; Stein & al., 2008; Street & al., 2005; Votta & Manion, 2003). Both the adaptive and maladaptive coping strategies that were used unequally by the two groups are more related to specific core elements constituting the PTSD syndrome, such as guilt and numbing, whereas coping strategies related to avoidance or its opposite, problem-focused coping, were used equally by the two groups. One can hypothesize that all study participants, being substance users in treatment, are characterized by their use of avoidance coping strategies and that, in this sample, being

in the PTSD + or PTSD – group is not sufficient to explain the variability of the use of avoidance or problem-solving coping strategies.

Limitations

Major limitations of this study include the size and origin of the sample, which came from a single clinical unit. The results might be conservative because studies show that patients, especially males, might hide traumatic events out of shame or guilt (Henning & Frueh, 1997) and minimize their symptoms, as documented in studies with police officers (Amaranto & Steinberg, Castellano & Mitchell, 2003; Miller, 2006). However, individuals in treatment for SUD normally report their symptoms reliably, as seems to have been the case during the interviews for this study (Weiss, Najavits, Greefield, Soto, Shaw & Wyner, 1998). The unavailability of lifetime alcohol and substance scores leads to limited interpretations because associations with trauma-related symptomatology can be more apparent over longer time periods. Verifying the lifetime interactions of different substance use problems as well as traumatic events would have been informative. Measuring the participants' use of their different social networks in addition to their perceived social resources would also have been informative.

Conclusion

In conclusion, the results of this study indicate that a more thorough understanding of the PTSD diagnosis among clinicians who care for the homeless is recommended. The clinical picture that emerges is that of a group of persons that has suffered since childhood, faced alcoholic parents, been without any social support, and not found ways to overcome the consequences of traumas except by the maladaptive use of substances, denial and self-blame. These persons will probably require long-term support to better deal with their suffering and to achieve more adaptive coping skills.

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Table 1.

Types of Trauma According to the TAA[1] by Sex, Age Experienced and MPSS-SR[2] Score

Types of Trauma (early trauma)[3]	Men (n = 42)		Women (n = 9)	
	PTSD -	PTSD +	PTSD -	PTSD +
War/Combat	0 (0)	3 (0)	0 (0)	0 (0)
Accident (work, car)	13 (1)	11 (1)	1 (0)	6 (4)
Natural Disaster	2 (1)	1 (0)	0 (0)	1 (0)
Sexual Aggression	7 (6)	9 (6)	2 (0)	6 (5)
Unarmed Physical Aggression	14 (5)	13 (7)	1 (0)	6 (4)
Armed Physical Aggression	16 (3)	13 (4)	1 (0)	5 (1)
Physical Aggression (any of both types)	21 (7)	18 (8)	1 (0)	7 (4)
Other : Serious Injury	7 (3)	6 (2)	0 (0)	1 (0)
Other : Scared of Dying	11 (0)	4 (2)	0 (0)	4 (1)
Aggression/Murder Witness	10 (5)	5 (3)	0 (0)	3 (1)
Assassination	1 (0)	0 (0)	0 (0)	2 (0)
Drunk Driver Victim	1 (0)	0 (0)	0 (0)	0 (0)
Other(s)	9 (2)	9 (2)	0 (0)	3 (2)

[1]Trauma Assessment for Adults-Self-Report.[2]Modified PTSD Symptom Scale Self-Report.[3]Note: Numbers appearing in parentheses are the number of individuals who experienced the specific trauma before 16 years of age.

Table 2.

Mean Differences in Study Variables Between With and Without an Alcoholic Parent and Specifically an Alcoholic Father

Variables		Do not have an alcoholic	Have an alcoholic	*t*	*df*	*d*
Score on the MPSS-SR[1]	Parent	36.91 (16.74)	56.48 (27.01)	-2.96**	26	-0.77
	Father	34.07 (16.63)	59.14 (26.13)	-4.05***	37	-1.05
Early Trauma	Parent	.27 (.47)	.78 (.42)	-3.41***	40	-1.18
	Father	.21 (.43)	.84 (.37)	-5.12***	49	-1.63
Early Physical Aggression	Parent	.09 (.30)	.45 (.50)	-2.97**	27	-0.77
	Father	.07 (.27)	.47 (.51)	-3.78***	43	-0.87
Early Sexual Aggression	Parent	.09 (.30)	.40 (.50)	-2.57*	27	-0.77
	Father	.07 (.27)	.43 (.50)	-3.31**	43	-0.80
Early Accident	Parent	0 (0)	.15 (.36)	-2.62*	39	-0.47
	Father	0 (0)	.16 (.37)	-2.64*	36	-0.50

Notes * = $p < .05$, ** = $p < .01$, *** = $p < .001$. Standard deviations appear in parentheses.

[1]Modified PTSD Symptom Scale Self-Report.

Table 3.
Mean Differences in Study Variables Between Groups That Did or Did not Experience Early Trauma

Variables	Did Not Experience Early Trauma	Experienced Early Trauma	*t*	*df*	*d*
Number of Traumatic Events	2.65 (1.11)	5.03 (1.96)	-4.63***	49	-1.38
Score on the MPSS-SR[1]	40.65 (22.72)	58.06 (26.32)	-2.33*	49	-0.69
Have an Alcoholic Father	.35 (.49)	.91 (.29)	-4.32***	22	-1.52
Have an Alcoholic Mother	.24 (.44)	.38 (.49)	-1.08	36	-0.30

Notes * = $p < .05$, ** = $p < .01$, *** = $p < .001$. Standard deviations appear in parentheses.
[1]Modified PTSD Symptom Scale Self-Report.

Table 4.

Mean Differences Between PTSD + and PTSD - Groups on the Main Variables of the Study

Variables (scores)	PTSD -	PTSD +	*t*	*df*	*d*
Addiction Severity Index Alcohol Scale	.18 (.16)	.32 (.29)	-2.12*	37	-0.60
Addiction Severity Index Drug Scale	.16 (.09)	.18 (.13)	-0.64	49	-0.18
Have an Alcoholic Parent	.62 (.50)	.96 (.20)	-3.28**	33	-0.90
Experienced an Early Trauma	.50 (.51)	.84 (.37)	-2.72**	46	-0.76
Social Provisions Scale	73.19(13.17)	68.12(13.42)	1.36	49	0.38
Brief Cope Positive Reframing Scale	6.58 (1.27)	5.36 (2.04)	2.55*	40	0.72
Brief Cope Humor Scale	5.42 (1.50)	3.80 (1.85)	3.45***	49	0.96
Brief Cope Acceptance Scale	7.08 (1.16)	5.48 (1.92)	3.58***	39	1.01
Brief Cope Denial Scale	3.42 (1.50)	4.48 (1.96)	-2.17*	49	-0.61
Brief Cope Substance Use Scale	4.31 (2.51)	5.76 (2.65)	-2.01*	49	-0.56
Brief Cope Self-Blame Scale	5.15 (1.78)	6.12 (1.59)	-2.04*	49	-0.52

Notes * = $p < .05$, ** = $p < .01$, *** = $p < .001$. Standard deviations appear in parentheses. Coping variables yielding no statistically significant results were not included in this table.

Conclusion

Fréquences de traumas et d'état de stress post-traumatique

Les traumas et le diagnostic d'ÉSPT entraînent des difficultés importantes dans différentes sphères de la vie chez les individus et peuvent entraîner des difficultés à bien conserver et obtenir des ressources financières pour assurer une stabilité résidentielle (voir Kim & Ford, 2006; Kim & al., 2010). Suite au stress causé par un trauma, le travail et les relations sociales des individus peuvent être affectés avant ou pendant l'itinérance. Ils sont également plus à risque de vivre des traumas une fois itinérants. Par ailleurs, il est également connu que les TUS peuvent se développer avant ou après des traumas et sont donc souvent associés aux ÉSPT (voir Ouimette & Brown, 2003). Les résultats de cette étude ont permis de confirmer que, dans un échantillon d'itinérants en traitement pour des TUS à Montréal, la totalité souffrait d'événements traumatiques au cours de leur vie et la quasi-majorité présentait des symptômes liés au diagnostic d'ÉSPT. Les résultats de l'étude ne nous permettent pas de confirmer que tous les itinérants en traitement pour des TUS sont à risque d'avoir un ÉSPT, étant donné la représentativité limitée de l'échantillon, mais ils reproduisent les résultats d'autres études auprès d'itinérants ayant des TUS (Christensen & al., 2005; Larney & al., 2009). Pourtant, bien que tous aient vécu un trauma, qu'ils soient tous itinérants et qu'ils aient tous des TUS, la moitié des individus ne présentent pas des symptômes d'une intensité et d'une sévérité suggérant un diagnostic d'ÉSPT. Il est donc

probable qu'une combinaison d'autres facteurs explique mieux pourquoi certains participants ont été plus à risque et d'autres mieux protégés face aux conséquences des traumas.

Alcoolisme parental et trauma dans l'enfance

Selon la documentation scientifique existante, l'alcoolisme parental, les traumas dans l'enfance et la symptomatologie liée à l'ÉSPT sont associés (Cloninger & al., 1981; Goodwin & al., 1973; Kendler & al.,1992; Koenen, 2006; Walsh & al., 2003). Quarante des 51 individus de notre échantillon ont eu un parent alcoolique. Les 34 individus qui ont vécu un trauma dans l'enfance ont tous eu un parent alcoolique. Selon notre étude, l'alcoolisme parental et l'expérience d'un trauma dans l'enfance sont caractéristiques des itinérants cherchant de l'aide pour des TUS. En outre, dans notre échantillon, avoir eu un parent alcoolique et avoir vécu un trauma dans l'enfance sont tous deux associés à avoir une symptomatologie reliée à un ÉSPT plus sévère. La majorité des participants ont non seulement vécu des difficultés durant l'enfance, mais ceux ayant davantage de symptômes reliés à l'ÉSPT à l'âge adulte ont eu encore plus de problèmes durant l'enfance.

Soutien social perçu

Il n'est pas surprenant qu'une transmission intergénérationnelle des problèmes ait pu se produire, car la majorité des participants n'ont également pas accès à des ressources sociales équivalentes à la population générale. Ces résultats confirment ce qui existe dans la documentation scientifique, soit que les itinérants et les gens aux prises avec des problèmes

de consommation ont accès à des ressources sociales limitées (Abdul-Hamid & Cooney, 1996; Herman & al., 1998; Morrell-Bellai & al., 2000; Nyamathi & al., 2000; Stein & al., 2008; Thompson & al., 2006). Il est très probable qu'ils n'ont jamais eu accès à des ressources sociales significatives depuis leur enfance, car nous savons que la majorité des participants vivaient dans un foyer familial où l'abus et la négligence étaient fréquents. Le soutien social perçu des participants n'a pourtant pas varié significativement selon la présence potentielle ou non d'un ÉSPT, contrairement à ce que la documentation existante permettait de prédire (Billette & al., 2008; Jovanovic & al., 2004; Higgins & al., 2003; Monson & al., 2005; Morrell-Bellai & al., 2000; Savage & Russell, 2005; Stein & al., 2008). Pourtant, dans notre étude, il existe une corrélation faible et négative entre le niveau de soutien social perçu et la gravité de la symptomatologie reliée à l'ÉSPT ($r(51) = -.34$, $p < .05$). Il est probable que pour certains participants, le soutien social a eu un effet protecteur relativement aux conséquences des événements traumatiques, mais cet effet a été insuffisant pour expliquer la différence entre ceux ayant plus ou moins de symptômes.

Stratégies de coping

La majorité des participants n'ont pas de ressource dans leur milieu pour leur venir en aide et doivent donc principalement compter sur leurs propres moyens. Selon notre étude, les participants plus susceptibles de développer un ÉSPT suite à un trauma ont appris à utiliser fréquemment des stratégies de *coping* inadaptées, notamment la consommation de substances, le déni et la culpabilisation, pour faire face au stress. Ces résultats confirment ce qui a été observé dans les études précédentes (Berman, & al., 1996; Stein & al., 2005;

Schuster, 2008; Street, & al., 2005). Non seulement ces stratégies de *coping* inadaptées causent des problèmes, mais elles peuvent les maintenir également, car elles ne sont pas centrées sur la résolution de ceux-ci. Il n'est donc pas surprenant que les participants de notre étude utilisant davantage des stratégies de *coping* inadaptées ont davantage de symptômes.

Recommandations cliniques

En terminant, le rédacteur se permettra quelques recommandations cliniques auxquelles il accorde une importance considérable. Premièrement, il est très important que les intervenants œuvrant dans des centres pour itinérants avec des problèmes de consommation de substances soient au courant qu'il est probable que leurs usagers présentent potentiellement un ÉSPT et qu'ils comprennent ce qu'est ce diagnostic et les influences qu'il peut avoir en traitement. Parmi ces influences, il existe un plus haut taux rechute et d'abandon de traitement dû en partie aux symptômes reliés aux traumas qui peuvent ressurgir une fois la consommation réduite ou arrêtée (Najavits, 2007). Deuxièmement, il est préférable que des outils de détection simples soient utilisés en début de traitement ou à n'importe quel moment durant le traitement si on se doute que l'usager a vécu un événement critique. Troisièmement, les meilleures pratiques suggèrent un traitement intégré pour cette comorbidité (Santé Canada, 2002). Ainsi, si un usager a vécu un événement potentiellement traumatique et/ou qu'il présente des symptômes reliés à un potentiel diagnostic d'ÉSPT, il est préférable de le référer à une ressource spécialisée pour mettre en œuvre un traitement en collaboration avec cette ressource, soit mettre en place un

traitement intégré pour les TUS et ÉSPT, comme le traitement cognitivo-comportemental *À la recherche de la sécurité* (voir Najavits). Le traitement *À la recherche de la sécurité* est très flexible, permet d'assurer un maximum de rétention en traitement et a déjà été largement validée auprès d'échantillons cliniques comparables au nôtre. Dans l'état actuel des connaissances, aborder ces problèmes comme un tout intégré garantit les meilleurs résultats.

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