



Is alexithymia related to cannabis use disorder? Results from a case-control study in outpatient adolescent cannabis abusers



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ABSTRACT

Objective: In recent decades, alexithymia has been considered a risk factor for multiple somatic and psychiatric conditions. Yet, whereas alexithymia has been extensively studied in adults with a substance misuse, only one study has reported data on cannabis abusers from the general population. Hence, our main objective was to explore alexithymia in a clinical sample of treatment-seeking young outpatients with a DSM-IV cannabis dependence or abuse diagnosis compared to controls.

Methods: 120 young patients (95 males - mean age 17.9 years (SD = 2.8; 14 to 25)) with a cannabis dependence or abuse (DSM-IV-TR criteria evaluated with the MINI), seeking treatment in an addiction unit, and 110 healthy control subjects (77 males - mean age 18.2 years (SD = 3.4; 14 to 25)) participated in the study. They completed a battery of self-reports measuring alexithymia (TAS-20; BVAQ-B), depression (BDI-13) and state and trait anxiety (STAI).

Results: 35.3% of cannabis users were alexithymic, and logistic regression analysis showed that the alexithymic components of difficulties identifying and describing feelings combined with trait anxiety predicted group membership.

Conclusion: This first study on young cannabis abusers and dependent subjects further emphasizes the importance of considering the affective style, and particularly the anxious temperament and alexithymia features, as factors associated with substance misuse during late adolescence.

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1. Introduction

Alexithymia, which literally translates as “no words for mood”, introduced by Sifneos in 1973, refers to a specific emotional disturbance characterized by an inability to identify internal affective states and describe them verbally [1]. In clinical settings, alexithymic patients demonstrate an inability to distinguish emotions from physical sensations and “pensée opératoire”, a distinctive cognitive style characterized by a preoccupation with the details of external events as well as a lack of fantasy [2,3].

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Rates of alexithymia in the general population (adolescents and adults) have been reported as approximately 10% (9–17% for men and 5–10% for women [4–7]), whereas estimates are as high as 70% in some clinical groups [8]. Alexithymia is alternatively considered a stable personality trait, a risk factor for physical illness and psychiatric disorders or a state reaction to various stressful situations [2,3,9]. Numerous studies have reported high levels of alexithymia in adult substance abusers, and some authors speculate that substances are used to compensate for deficits in emotional self-awareness [10]. Using self-report questionnaires (the Toronto Alexithymia Scales, TAS and TAS-20), rates of alexithymia ranged from 39% to 67% in adults diagnosed with substance abuse or dependence [9–12]. Recent publications concluded in favor of a relative stability of alexithymia in substance abusers [13]. Some other recent studies in samples from the general population investigated differences in alexithymia rates and levels in relation to the age of the sample [14–18]. Thus, it seems important to determine these rates in younger samples of substance abusers since the involvement of alexithymia may vary with age. In a French study [19], the

prevalence of alexithymia was 43.9% among 68 young substance abusers (substance not specified; age range from 15 to 24). Surprisingly, although alexithymia has been extensively studied in various substance use disorders, only Troisi et al. [20] measured it specifically in young cannabis abusing/dependent subjects in a community sample. They reported the prevalence of alexithymia (using the TAS-20) to be 30% among their 88 subjects with a cannabis abuse or dependence diagnosis. Nevertheless, the investigation of alexithymic features among adolescent cannabis abusers remains insufficient, and is inexistent in a clinical setting. This gap in the literature is even more surprising given that the proportion of cannabis users have considerably increased during the past few decades [21] and cannabis is the illegal substance most commonly abused by French young people; it has become a major public health concern [22].

Hence, this cross-sectional study was designed to investigate alexithymia in young outpatient cannabis misusers relative to matched control cases. Knowing the frequent association between alexithymia and negative affective state [23], we also examined whether the differences in alexithymia scores between the cannabis abusers (CA) and control participants remained after controlling for the effects of the severity of anxious and depressive symptoms. Our subsequent objective was to determine whether the levels of alexithymia and state and trait anxiety and depression predict cannabis misuse by adolescents.

2. Methods

2.1. Participants

One hundred and twenty adolescents and young adults (95 males), with a mean age of 17.9 years ($SD = 2.8$, 14–25), each diagnosed with a substance (cannabis) use disorder, were included in the group of cannabis abusers (CA). Participants were outpatients, recruited in addiction units located in Paris and its suburbs: 110 met the DSM-IV diagnostic criteria for cannabis dependence, and 10 met those for cannabis abuse only (using the appropriate section of the Mini-International Neuropsychiatric Interview (MINI) [24]). The mean age of first cannabis use was 13.9 (± 1.9) years and the average duration of regular cannabis use was 40.6 months (± 28.8) at the time of the patients consultation. During the previous month, they had smoked on average 5.01 (± 3.2) joints per day.

Regarding their educational level, 11.7% were in middle school (14–15 years), 46.7% in high school (15–18 years), 21.7% in vocational school (14–18 years), 17.5% were college students (18 years and more) and 2.5% were out-of-school. The classification of the French National Institute for Statistics and Economic Studies (INSEE) was used to categorize the economic status of the participants' families. When both parents were working (55%), the higher professional status was used. Among the 120 participants, 11.5% had parents working as craftspeople, storekeepers, tradespeople, or heads of business; 38.9% had parents who were high level white-collar workers or intellectual professionals; 29.2% had parents working in intermediate professions (e.g., teachers, intermediate workers in the health and social sectors, intermediate administrative and business workers); 15.9% had parents working as public employees, police officers and military staff members, or in sales), and for 4.4%, the professional status of the parents was not specified.

One hundred and ten adolescents and young adults (77 males), matched for age and level of education, with a mean age of 18.2 years ($SD = 3.4$; 14–25), were included in the control group. They were recruited from several schools and public organizations located in Paris and its suburbs. All were free of illicit drug use diagnosis (abuse or dependence) as evaluated by the MINI.

For both samples, exclusion criteria were mental retardation, organic brain disease, chronic or severe somatic disorder, psychotic disorder (evaluated by the appropriate MINI section), and an inability to read or fill out the questionnaires.

Patients were referred by their clinicians to the evaluator of the research (GD). The objectives and the course of the study were presented to the patients during this first meeting. The same information was given to the controls during school prevention programs or individual meetings. The Pitié-Salpêtrière Hospital Ethics Committee approved the protocol, and all subjects (and at least one parent for those under 18 years of age) gave their written informed consent.

2.2. Materials

The French version of the Mini International Neuropsychiatric Interview (MINI 5.0.0) [24] was used to assess cannabis abuse or dependence. Furthermore, participants completed several self-reports including:

The 13-item Beck Depression Inventory (BDI-13) [25,26]: individuals are asked to respond to statements on the basis of how they have felt over the past week. Examples are the following: "I do not feel sad" = 0; "I feel sad" = 1; "I am sad all the time and I can't snap out of it" = 2; "I am so sad and unhappy that I can't stand it" = 3. BDI-13 scores were considered a continuous variable (total score varied from 0 to 39), as well as a categorical variable, using the validated cut-off scores: no depressive symptoms: ≤ 3 ; mild depressive symptoms: 4–7; moderate depressive symptoms: 8–15; severe depressive symptoms: ≥ 16 [26].

The State and Trait Anxiety Inventory-Form Y (STAI-Y) [27,28]: subjects are asked to report the extent of their anxiety at present (State-STAI) (20 items) (e.g., "I feel tense") and the intensity of their anxiety in general (Trait-STAI) (20 items) (e.g., "I feel nervous and restless"). For each scale, scores range from 20 to 80, and in order to facilitate interpretation, scores can be ranked in 5 levels: very low: ≤ 35 ; low: 36–45; mild: 46–55; high: 56–65; very high: > 65 [28].

The 20-item Toronto Alexithymia Scale (TAS-20) [29,30] captures three interrelated and core alexithymic features: Difficulty identifying feelings (DIF) (e.g., "I am often confused about what emotion I am feeling"), Difficulty describing feelings (DDF) (e.g., "It is difficult for me to find the right words for my feelings"), and External thinking (EOT) (e.g., "I prefer talking to people about their daily activities rather than their feelings"). We used the alexithymia cut-off scores established for French samples (non-alexithymic: < 44 ; intermediate: 45–55; alexithymic: > 56) [31]. In our total sample, Cronbach's alpha coefficients were: DIF = 0.74; DDF = 0.69; EOT = 0.39.

The Bermond and Vorst Alexithymia Questionnaire - Form B (BVAQ-B) [32,33] measures the alexithymia construct in 20 items. Factor analyses have consistently supported a five-factor structure: Verbalizing (B1) (e.g., "People often say that I should talk about my feelings"), Fantasizing (B2) (e.g., "Fantasizing about imaginary things or events is a waste of time, I think"), Identifying (B3) (e.g., "When I am fed-up, it remains unclear to me whether I am sad or afraid or unhappy"), Emotionalizing (B4) (e.g., "When I see somebody crying terribly, I remain unmoved"), and Analyzing (B5) (e.g., "I think it is strange that others analyze their emotions so often"). Total scores range from 20 to 100, and subscale scores range from 4 to 20. We used the cut-off scores established for French samples: non-alexithymic: ≤ 43 ; intermediate: 44–52; alexithymic: ≥ 53 [34]. In our total sample, Cronbach's alpha coefficients were: B1 = 0.66; B2 = 0.58; B3 = 0.38; B4 = 0.35; B5 = 0.61.

2.3. Statistical analysis

Of the 120 cannabis abusers, 20 did not complete the BDI-13 due to a printing error. Regarding the control subjects, one participant left the TAS-20 uncompleted and 3 had a BVAQ-B partially uncompleted. Consequently, the statistical analyses with the BDI-13 included 100 CA subjects, those with the TAS-20 included 109 controls and those with the BVAQ-B included 107 control participants.

Descriptive statistics for quantitative measures (mean, variance, standard deviation) and for qualitative measures (percentage) were first calculated. Independent-samples *t*-tests were used to estimate

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