Substance Abuse and the Torture Survivor Experience

presented by

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State-of-the-science about substance use problems among refugees and torture survivors

Eric F. Wagner, Ph.D.
Professor
Florida International University
Longstanding Recognition

- people who have been forcibly displaced from their homes by:
  - armed conflict
  - human rights abuses
  - persecution

are at elevated risk for hazardous and harmful substance use (Johnson, 1996; de Jong, 2002; UNHCR and WHO, 2008)

- UNHCR, WHO, & IASC have produced clinical guidelines and accompanying research (IASC, 2007; UNHCR and WHO, 2008; Ezard et al., 2011)
“Alcohol and drug abuse often develops secondarily in torture survivors as a way of obliterating traumatic memories, regulating affect and managing anxiety.”
“There is considerable evidence from other populations at risk for PTSD that substance abuse is a potential co-morbid diagnosis for torture survivors”
Self-Medication Model

• popularized during the 1970s
• physical or mental suffering leads to experimentation with various drugs to alleviate troubles
  – coping strategy in response to exposure to traumatic events and social stressors
• depending on access, they may search until they find a specific drug for their specific needs
  – “drug of choice”
SOCIAL WORK EDUCATION FOR THE PREVENTION AND TREATMENT OF ALCOHOL USE DISORDERS

Audrey L. Begun, PhD, MSW, Editor
Problems suffered by immigrants:
- Racism
- Discrimination
- Language barriers
- Loss of valued social roles
- Depression
- Suicide
- Parent/child conflict
- PTSD
- Substance abuse

Additional problems suffered by refugees:
- Persecution
- Hardship or torture
- Refugee camps
- No medical/disability services

Additional problems suffered by undocumented individuals:
- Constant threat of deportation
- No legal protection
- Open to exploitation
- Not qualified for government assistance programs
Alcohol Use Models

- Acculturative Stress Model
- Assimilation/Acculturation Model
- Continued Original Patterns
- Intercultural Diversity Model
Literature revelations

• Co-morbidity of PTSD with other disorders is common
• Systemic research has seldom studied the abuse of substances by torture survivors
• Populations that suffer from PTSD, including refugees, prisoners of war, and veterans of armed conflict reveal
  1. substance abuse prevalence varies by ethnic or cultural group
  2. former POWs with PTSD were at increased risk for substance abuse
  3. combat veterans have high rates of co-morbidity of PTSD and substance abuse
• Therefore, the evidence from other populations at risk for PTSD demonstrates that substance abuse is a potential co-morbid diagnosis for torture survivors.

EVIDENCE OF TORTURE
Council of Europe, Pétur HAUKSSON,
Strasbourg, 6 November CPT (2003) 912004, p.23
Refugees and Hazardous Alcohol Use

• higher levels of hazardous alcohol use among men compared with women (Jenkins et al., 1990; Kozaric-Kovacic et al., 2000; Marshall et al., 2005; Steel et al., 2005; Puertas et al., 2006; Jeon et al., 2008; Lee et al., 2008; Roberts et al., 2011; Ezard et al., 2012)

• age findings mixed...
  – younger age associated with hazardous alcohol use in two studies of South East Asian refugees in the USA (Marshall et al., 2005; Lee et al., 2008)
  – older age associated with hazardous alcohol use in northern Uganda (Roberts et al., 2011)

• associations between hazardous drinking and exposure to violent and traumatic events, both from the conflict and after displacement
An Illustrative Study: Blight et al., 2008

- community sample of adults who had come from Bosnia-Herzegovina to Sweden in 1993/94 due to the war (i.e. refugees)
- the prevalence estimates for alcohol consumption were low
- gender differences in alcohol consumption, with a higher prevalence among men
Management of AOD problems in refugee settings

Individual

Legal

Social

Psychological

Brewer (2010, p. 278)
Annual Per Capita Consumption (PCC)

PCC in litres pure alcohol

- 0 – 6 L
- 6 – 12 L
- 12 – 25 L
Spectrum of Alcohol Use

Use
Consequences
Repetition
Loss of control, preoccupation, compulsivity, physical dependence
A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. Alcohol 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 alcohol use.
3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
4. Craving, or a strong desire or urge to use alcohol.
5. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
8. Recurrent alcohol use in situations in which its physically hazardous.
9. Alcohol 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 alcohol.
10. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.
    b. A markedly diminished effect with continued use of the same amount of alcohol
11. Withdrawal, as manifested by either of the following:
    a. The characteristic withdrawal syndrome for alcohol.
    b. Alcohol (or a closely related substance, such as benzodiazepine) is taken to relieve or avoid withdrawal symptoms

ADDITIONAL SPECIFIERS
Specify if: In early remission, In sustained remission
Specify if: In a controlled environment
Specify current severity: Mild (2-3 symptoms), Moderate (4-5 symptoms), Severe (6 or more symptoms)
Using the NIAAA Clinician’s Guide

A note to Instructors:
This slide show is a companion to the NIAAA Clinician’s Guide. NIAAA introduces a new free online training resource: Video Cases based on the Clinician’s Guide.

- Free CME/CE credits offered by Medscape.com
- For details and links, visit www.niaaa.nih.gov/guide

Helping Patients Who Drink Too Much

A CLINICIANS GUIDE
Updated 2005 Edition

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
National Institutes of Health
National Institute on Alcohol Abuse and Alcoholism

New Supporting Materials
1. Do not assume that all alcohol and substance use disorders are related to the situation in the refugee camp
2. Promote understanding to facilitate interventions
3. The entire community is affected by alcohol and substance use, not only the users
4. Involve refugees in coordinated initiatives
5. Collect information using specific methods and instruments
6. Develop a horizontal, rather than a vertical, approach to alcohol and substance use
Practical Guidelines
Streel & Schilperoord (2010)

• Vertical approaches should be avoided
• Epidemiological data must be conducted
• Community based approaches and coordinated actions are usually best
  – Where a tribal or wider social structure remains reasonably intact, recruiting community leaders to spread the word and help identify need
Future Research

• limited understanding of how and why patterns of alcohol use may change as a result of forced displacement

• no high quality data on the effectiveness of alcohol-related interventions for forcibly displaced persons or refugees

• a community-based participatory research approach is essential
Clinical Insights on Substance Abuse in Refugee and Torture Survivors

Richard F. Mollica, MD MAR

Harvard Program in Refugee Trauma
Massachusetts General Hospital
Professor of Psychiatry, Harvard Medical School
Basic Points

• Know the drugs and alcohols commonly used in different cultures—e.g. Cambodian women

• Overcome the fear of “blaming the victim”
Basic Points

• While collecting the trauma story ask about increase in high risk behaviors
  – Unsafe sex
  – Cigarette smoking
  – Substance abuse

• Assess the motivation to change (self efficacy)
  – “Do you have the belief you can become a whole person again”
Basic Points

• Trauma is highly associated with substance abuse & vice versa
• Treat the PTSD and substance abuse along parallel tracks
Basic Points

• If someone is not getting better – think THI & substance abuse (e.g. Hmong)

• Remember that bipolar hypomanic patients abusing substances are at a high risk for suicide or violence
Basic Points: Safety First

- Patients addicted or dependent on benzodiazepines and prescription drugs can be extremely dangerous to the therapist.
- They often bully, threaten, and/or scream at the clinician.
- They also may be selling the drugs.
Substance Abuse and Trauma: The Magnitude of the Problem

Epidemiologic and clinical research has demonstrated that trauma exposure among individuals with substance abuse is almost universal.

- Up to 45% of substance abusers experience co-morbid PTSD
- Up to 45% of patients with PTSD have a co-morbid substance abuse problem
The ACE Study: Childhood Abuse Categories

• Direct exposure to childhood abuse
  – Psychological
  – Physical
  – Sexual

• Household dysfunction during childhood
  – Substance abuse
  – Mental illness
  – Mother treated violently
  – Criminal behavior in household

# The ACE Study: The Relationship Between Childhood Abuse & Household Dysfunction (n=9,508)

## Relationship Between Childhood Trauma and Medical Risk Factors

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>%</th>
<th>AOR</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Smoker</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>6.8</td>
<td>1.0</td>
<td>(1.1-1.8)</td>
</tr>
<tr>
<td>2</td>
<td>10.3</td>
<td>1.5</td>
<td>(1.7-2.9)</td>
</tr>
<tr>
<td>4+</td>
<td>13.9</td>
<td>2.0</td>
<td></td>
</tr>
<tr>
<td><strong>Severe Obesity (BMI&gt;35)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>5.4</td>
<td>1.0</td>
<td>(1.1-1.9)</td>
</tr>
<tr>
<td>2</td>
<td>9.5</td>
<td>1.4</td>
<td>(1.2-2.1)</td>
</tr>
<tr>
<td>4+</td>
<td>12.0</td>
<td>1.6</td>
<td></td>
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<tr>
<td><strong>2 or more weeks of depressed mood in past year</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>14.2</td>
<td>1.0</td>
<td>(2.1-3.2)</td>
</tr>
<tr>
<td>2</td>
<td>31.5</td>
<td>2.4</td>
<td>(3.8-5.6)</td>
</tr>
<tr>
<td>4+</td>
<td>50.7</td>
<td>4.6</td>
<td></td>
</tr>
<tr>
<td><strong>Ever attempted suicide</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>1.2</td>
<td>1.0</td>
<td>(2.0-4.6)</td>
</tr>
<tr>
<td>2</td>
<td>4.3</td>
<td>3.0</td>
<td>(8.5-17.5)</td>
</tr>
<tr>
<td>4+</td>
<td>18.3</td>
<td>12.2</td>
<td></td>
</tr>
<tr>
<td>Risk Factors</td>
<td>%</td>
<td>AOR</td>
<td>95% CI</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------</td>
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<td>------------</td>
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<tr>
<td>Considers self alcoholic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>2.9</td>
<td>1.0</td>
<td>(3.0-5.3)</td>
</tr>
<tr>
<td>2</td>
<td>10.3</td>
<td>4.0</td>
<td>(5.4-10.2)</td>
</tr>
<tr>
<td>4+</td>
<td>16.1</td>
<td>7.4</td>
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</tr>
<tr>
<td>Ever use illicit drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>6.4</td>
<td>1.0</td>
<td>(2.4-3.6)</td>
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<tr>
<td>2</td>
<td>19.2</td>
<td>2.9</td>
<td>(3.7-6.0)</td>
</tr>
<tr>
<td>4+</td>
<td>28.4</td>
<td>4.7</td>
<td></td>
</tr>
<tr>
<td>Ever injected drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>1.3</td>
<td>1.0</td>
<td>(1.8-8.2)</td>
</tr>
<tr>
<td>2</td>
<td>1.4</td>
<td>3.8</td>
<td>(4.9-21.4)</td>
</tr>
<tr>
<td>4+</td>
<td>3.4</td>
<td>10.3</td>
<td></td>
</tr>
<tr>
<td>Ever had sexually transmitted disease</td>
<td>5.6</td>
<td>1.0</td>
<td>(1.2-1.9)</td>
</tr>
<tr>
<td>0</td>
<td>10.4</td>
<td>1.5</td>
<td>(1.9-3.2)</td>
</tr>
<tr>
<td>2</td>
<td>16.7</td>
<td>2.5</td>
<td></td>
</tr>
<tr>
<td>4+</td>
<td></td>
<td></td>
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</tbody>
</table>
2004-2005 Wave 2 NESARC Study (n = 34,653) (USA)

Lifetime risk for partial and full PTSD

Partial PTSD 6.6%

Full PTSD 6.4%

<table>
<thead>
<tr>
<th>Event</th>
<th>No PTSD (%)</th>
<th>Partial PTSD (%)</th>
<th>Full PTSD (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual assault</td>
<td>1.7</td>
<td>12.7</td>
<td>9.2</td>
</tr>
<tr>
<td>Seeing someone badly injured or dead</td>
<td>4.3</td>
<td>4.6</td>
<td>5.8</td>
</tr>
<tr>
<td>Beaten by intimate partner</td>
<td>0.7</td>
<td>3.0</td>
<td>5.3</td>
</tr>
<tr>
<td>Unexpected death of someone close</td>
<td>22.7</td>
<td>26.2</td>
<td>24.1</td>
</tr>
<tr>
<td>Serious illness/injury of someone close</td>
<td>23.0</td>
<td>15.0</td>
<td>15.7</td>
</tr>
</tbody>
</table>
2004-2005 Wave 2 NESARC Study: Co-Morbidity of PTSD and Substance Abuse

<table>
<thead>
<tr>
<th>Condition</th>
<th>No PTSD (%)</th>
<th>Partial PTSD (%)</th>
<th>Full PTSD (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any alcohol or drug abuse</td>
<td>37</td>
<td>43.3</td>
<td>46.4</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>34.9</td>
<td>40.5</td>
<td>41.8</td>
</tr>
<tr>
<td>Drug abuse</td>
<td>11.4</td>
<td>17.4</td>
<td>22.3</td>
</tr>
<tr>
<td>Nicotine dependence</td>
<td>21.9</td>
<td>34.1</td>
<td>37.9</td>
</tr>
<tr>
<td>Lifetime suicide attempt</td>
<td>2.3</td>
<td>9.2</td>
<td>13.9</td>
</tr>
</tbody>
</table>
Australian National Survey of Mental Health and Well-Being (n = 10,641)

In the previous 12 months:
• 1.3% met criteria for PTSD
• 7.9% substance abuse
• 6% alcohol abuse
• 2.2% cannabis abuse
• 0.5% sedative use
• 0.4% amphetamines
• 0.3% opioid use

Australian National Survey of Mental Health and Well-Being: Prevalence of Substance Abuse with PTSD

34% of those with PTSD had a substance abuse disorder
# Prevalence of PTSD and Suicide Attempts in Inpatients Hospitalized with Substance Use Disorders (n = 253) (Australia)

<table>
<thead>
<tr>
<th>Substances</th>
<th>PTSD (%)</th>
<th>Suicide attempt (%) (ever)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol abuse</td>
<td>45.2</td>
<td>35.8</td>
</tr>
<tr>
<td>Opioid</td>
<td>47.5</td>
<td>34.3</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>55.2</td>
<td>56.7</td>
</tr>
<tr>
<td>Stimulants</td>
<td>48.9</td>
<td>46.8</td>
</tr>
<tr>
<td>Cannabis</td>
<td>46.7</td>
<td>41.8</td>
</tr>
</tbody>
</table>

Treatment Study #1 (USA)

Hien DA et al.

**Recruitment**
- 353 women
- Partial or full PTSD
- Substance use diagnosis and use in past 6 months
- Ages 18-65

**Treatment**
- “Seeking Safety” trauma treatment
- Health promotion education
- Random allocation

Outcomes

• Improvement in PTSD was found to impact substance abuse outcomes, primarily in those with heavy baseline substance abuse.

• Improvement in substance abuse had no impact on PTSD.

Treatment Study #2 (Australia)
Mills et al. 2012

Recruitment
• 103 men and women
• PTSD and substance use disorder (SUD)

Treatment
• Exposure therapy plus usual care for SUD
• Usual care for SUD
• Random allocation

Treatment Study #2 (Australia)  
Mills et al. 2012

Results

- Significant reduction in PTSD symptoms in both groups, with greatest reduction with exposure therapy
- Improvement in PTSD, despite continued use of substance during study (abstinence not required)
- Both groups improved in substance use reduction; exposure therapy no better for reducing substance use
- High drop out rates

Major Hypotheses for High Rates of PTSD in Substance Use Disorders

- Self-medication
- High risk behaviors
- Susceptibility
- Common biological factors
5 Major Building Blocks for Creating a Culture of Trauma Informed Care (TIC)

- Trauma Story
- Health Extenders
- TIC
- Self-healing
- Health Promotion
- Culture- and evidence-based treatment
Advancing Promising Practices in the Torture Treatment Field

For more technical assistance information, please contact:

National Partnership for Community Training
(T) 305.275.1930
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In partnership with Harvard Program in Refugee Trauma (HPRT) and the Bellevue/NYU Program for Survivors of Torture, National Partnership for Community Training (NPCT), is a program of Gulf Coast Jewish Family and Community Services.