Substance Abuse and the Torture Survivor Experience

Just because someone is a survivor of torture does not mean they are more likely to develop drug or alcohol use problems; however, people who have been forcibly displaced form their homes by armed conflict, human rights abuses, or persecution are reportedly at a higher risk for hazardous and harmful substance use. Alcohol and substance abuse often develop secondarily in torture survivors as a way of obliterating traumatic memories, regulating affect, and managing anxiety.

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
- Systemic research has seldom studied the abuse of substances by torture survivors; however, populations that suffer from PTSD, including refugees, prisoners of war, and veterans of armed conflict reveal:
  - Substance abuse prevalence varies by ethnic or cultural group
  - Former POWs with PTSD are at an increased risk for substance abuse
  - Combat veterans have high rates of co-morbidity of PTSD and substance abuse
- Associations between hazardous drinking and exposure to violent and traumatic events, both from the conflict and after displacement are clear. If you are exposed to violent and traumatic events, you are likely to have some degree of post traumatic symptomatology, which increases the risk that you will engage in hazardous drinking and drug use. This is the causal chain.

Substance Abuse Patterns

Non-problem use – No negative consequences or a compulsion to use but perhaps repeated patterns on occasion, but not compulsive repetition

At risk use – Starting to have negative consequences, fights with significant others, minor legal problems, hung-over and preforming poorly at school or work,; negative consequences might lead to reconsidering substance use, however if they don't reconsider, they move down the continuum towards problem use

Problem use – Despite negative consequences, they repeat the substance use and continue to have negative consequences

Dependency – Using substances, but lots of negative consequences, repeated use despite the consequences, demonstrate things like loss of control, preoccupation, compulsivity, physical dependence (physical and psychological withdrawal symptoms)

Substance Abuse Models

Self-medication model - Most discussed in characterizing why survivors of torture might be at a higher risk for substance use. Substance abuse often occurs when a client medicates themselves without the advice of a physician. Self medication causes the consciousness to change; thereby allowing one to decrease feelings of anxiety and memories of the horrific and horrible events. This coping strategy is a response to exposure to traumatic events and social stressors. Depending on access, clients may search until they find a specific drug to meet their specific needs.

Acculturative Stress Model - Alcohol and drug use occur because people are experiencing extreme stress, due to the immigration experience which is a source of cultural conflict and speaks to a lack of social and economic resources available to the person because they are in a new community. The stress of acculturating to a new society builds up and one way to decrease that stress temporarily is through the use of alcohol or other drugs.

Assimilation/Acculturation Model - As newcomers adapt to the host country, their patterns of drug use begin to reflect those of the new location. Their substance use looks more like that of the host country. This is especially true when their home country doesn't have high rates of alcohol or drug use. Alcohol and drug use becomes a function of acculturative aspiration rather than acculturative stress.

Continued Original Patterns - Typically seen in those coming from a heavy alcohol and drug use culture. The client is continuing the same pattern.

Intercultural Diversity Model – This model posits that not all members of a refugee group will fit neatly into one particular model. Individual differences exist among refugee group members. Therefore, substance abuse may be some combination of all models.

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Clinical Considerations

Intake:

- The trauma story is the centerpiece of the intake evaluation and treatment. While collecting the trauma story ask about increase in high risk behaviors such as unsafe sex, cigarette smoking, and substance abuse.
- Include drug and alcohol use in the intake process and screen for problematic use
- Inquire about the start of substance use, as it may not have started after the traumatic experience
- Overcome the fear of "blaming the victim"

Treatment Protocol:

- Utilize social support in recovery from alcohol or drug problems, which include the psychological and the legal aspects. Empower the user, the family, and the community by involving them in community based approaches and coordinated actions.
- Focus on the whole individual and their particular risk factors as well as the social milieu in which these problems occur. Alcohol and substance abuse affect the entire community, not just the individual user.
- Know the drugs and alcohols commonly used in the culture of your clients
- Implement holistic interventions that treat the whole individual and address immediate needs such as housing, employment, legal, spiritual, medical and psychological care
- Educate clients on the medical and psychological effects and impact of substance use
- Treat PTSD and substance abuse along parallel tracks because trauma and substance abuse are highly associated

Treatment Evaluation:

- Assess the motivation for change (efficacy). If the client does not believe they can heal and become a "whole person again" and are using substances to cure that pain, substance abuse treatment may prove problematic.
- If someone is not getting better, think about a traumatic head injury
- Remember that bipolar hypomanic patients abusing substances are at a high risk for suicide or violence. Patients addicted or dependent on benzodiazepines and prescription drugs can be extremely dangerous to the therapist.

Withdrawal symptoms depend on the substance, duration, and time spent using

Alcohol	Anxiety, agitation, shakes, sweats, vomiting
Hypnosedatives	Anxiety, irritability, shakes, sleep difficulties
Opioids	Anxiety, agitation, diarrhea, dilated pupils, nausea, sweating, vomiting, pain
Psychostimulants	Depression, fatigue, irritability, nausea, sleeplessness, suicidal ideation, vomiting, pain

Risk and harm linked to alcohol and substance use

Gender based violence and domestic violence
Legal problems
Neglect of family and children
Financial problems
Increased health problems resulting from use such as overdose, withdrawal symptoms
Risky sexual behavior leading to an increased risk for HIV transmission and other blood borne illnesses
Increased mental health problems - substance induced or exacerbated mental and behavior disorders
Loss of relationships
Suicidal ideation

This information guide is based on an NPCT webinar on this topic presented by the director of Florida International University's Community Based Intervention Research Group and professor, Dr. Eric Wagner and the Director of the Harvard Program in Refugee Trauma of Massachusetts General Hospital and Harvard Medical School, Dr. Richard Mollica. The webinar is archived on our website, www.gcjfcs.org/refugee under Webinars.

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The National Partnership for Community Training and the Florida Center for Survivors of Torture are programs of Gulf Coast Jewish Family & Community Services. This publication was funded by the Office of Refugee Resettlement. For more information on this document and for research purposes, contact partnership@gcjfcs.org. (305) 275-1930. NPCT is a training and technical assistance program which enhances awareness about the impact of political torture and teaches skills to respond appropriately using trauma-informed care principles. It is a partnership of the Florida Center for Survivors of Torture (FCST), the Harvard Program in Refugee Trauma (HRPT) and the Bellevue/NYU Program for Survivors of Torture (PSOT).

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