

Women & Children & Substance Use Disorders

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Objectives

- ◆ Identify the role of trauma in women and children in substance abuse disorder.
- ◆ Outline trauma-informed care framework for caring for women and children with substance use disorders.
- ◆ Outline the considerations for medication management of women and children with complex presentations of PTSD, mood, anxiety, psychosis and substance use disorders.

Women and SUD

- ◆ Women have an earlier age of initiation of substance use and a more rapid progression to drug involvement and dependence than men (Zilberman et al., 2003)
- ◆ Women expose themselves to more health risk factors, such as prostitution to secure drugs and sharing syringes, leading to a higher rate of new infections with HIV and other infectious diseases such as hepatitis (Maher et al, 2006)
- ◆ Opioid-dependent women show mortality rates 13 to 17 times higher than the general population (Bauer et al., 2006)

Women and SUD

- ◆ Estimates are that in the US, 1 in 4 pregnant women used substances in the past 30 days, including tobacco, alcohol and other illicit drugs (Havens et al., 2009)
- ◆ Illicit drug use during pregnancy is associated with small head circumference, neurological abnormalities, premature birth, LBW and perinatal morbidity (El-Mohandes et al., 2003)

Urban vs. Rural women and SUD?

- ◆ In study by Shannon et al., 2010, rural pregnant women have significantly different substance use patterns than urban women
- ◆ Greater proportion of rural pregnant women reported illicit opiate use, illicit benzo use and other substances
- ◆ Rural pregnant women had higher rates of injection drug use
- ◆ Saw higher rates of prescription drug abuse rather than heroin

Opiates and women

- ◆ Women opioid-dependent patients entering opioid agonist therapy were significantly more likely to have had a shorter duration of opioid addiction before starting treatment and showed more psychiatric and family problems compared to males (Schottenfeld et al., 1998; Petry et al., 2000; Karantzou et al., 1994)
- ◆ Co-occurring psychiatric problems, such as mood disorders and past and present sexual abuse, were seen more frequently in drug-dependent pregnant women compared to a control group of women (Jones et al, 2005)
- ◆ Between 56 and 73% of opioid-dependent pregnant women suffer from a major psychiatric disorder (Fitzsimons, 2007)

Opiates and women

- ◆ In the opiate-dependent patient the effects of mood disorders are usually detrimental, resulting in patterns of harmful health behavior during pregnancy, post-partum depression and consequences on mother-child interaction (Bonari et al., 2004; Cohen et al., 2004)
- ◆ Almost every SSRI, mood stabilizer and antipsychotic has severe and significant drug interactions with methadone and Buprenorphine except lamotrigine

Adolescents and children and SUD

- ◆ Recent surveys indicate that there are over 300,000 adolescents with alcohol dependence in the US
- ◆ There are no treatment protocols specifically for alcohol dependence and VERY few treatment centers
- ◆ MJ is the most widely used illicit drug among HS students
- ◆ Strongest predictor of future cocaine use is MJ use in adolescence
- ◆ The use of meth is increasing significantly among adolescents
- ◆ The use of inhalants is seen more often in middle school than HS but are seeing continued use

Sadock and Sadock, 2009

Complex Presentations

- ◆ What is withdrawal, intoxication, what is depression, anxiety, mania, hypomania, and PTSD?
- ◆ Women/children/adolescents with co-morbid substance and psychiatric symptoms do not fit the DSM criteria for our current psychiatric disorders
- ◆ Almost every withdrawal state includes symptoms of many psychiatric disorders
- ◆ What are the long-term effects of meth and designer drugs on the brain and how do they impact our diagnoses?
- ◆ Using more mood disorder NOS, anxiety disorder NOS, bipolar NOS in substance treatment settings and no real guidelines or evidence-based practice on significant substance and psychiatric co-morbidities to guide our decision-making

Angie, Raquel, and Evan

- ◆ Angie is a 24 year old mixed race Hispanic, African American, and Caucasian who has been placed in a residential treatment center to treat meth dependence, MJ dependence, and alcohol dependence. Social Services has placed her here to "prove" she can care for 4 year old Raquel and 1 year old Evan.
- ◆ Angie describes a history of trauma starting at age 6 including sexual and physical abuse, rape at age 14, gang raped at age 18. Her 2 children have 2 different fathers, both now in prison for selling meth. Angie has significant nightmares, flashbacks, irritability lasting weeks at a time, middle insomnia, hx of days without sleep but she is unable to tell you if this was off meth or other drugs or was using them during these symptoms. She describes significant depression, concentration problems, a tremendous amount of **guilt, and tells you she does not want medications that will make her gain weight as she admits to using meth to control her weight.** Raquel is demonstrating behavior problems on the unit and Evan is showing slow language skills.

McDevitt-Murphy et al., 2010 study

- ◆ investigated relationships between psychopathology and substance use and abuse in a sample of trauma-exposed college students.
- ◆ Analyses suggested that participants with PTSD tend to exhibit more extreme profiles of substance abuse
- ◆ Participants with PTSD reported having more drinks per occasion and drinking to higher levels of intoxication
- ◆ Findings suggest a more hazardous pattern of alcohol use among participants with PTSD
- ◆ This pattern is consistent with a large body of literature suggesting a strong relationship between PTSD and alcohol abuse (Quimette & Brown, 2003), and in particular, a recent study of adults suggesting that PTSD placed individuals at higher risk of heavy drinking, compared to major depressive disorder, or other anxiety disorders (Arch, Craske, Stein, Sherbourne, & Roy-Bourne, 2006).

Alcohol dependence and PTSD?

- ◆ Reported lifetime co-morbidity rates of alcohol dependence and PTSD to be 27%
 - ◆ Women with PTSD were nearly 4 times at greater risk of developing alcohol dependence (AD)
 - ◆ Co-morbidity of AD and PTSD associated with higher rates of relapse and medical problems
 - ◆ Some association between re-experiencing and more alcohol use disorders
- McCarthy and Petrakis, 2010

Trauma and women and SUD?

- ◆ Co-morbidity of SUD and PTSD in women has been documented for years but very little data on trauma and children/adolescents
- ◆ PTSD/SUD complicates and worsens each of these disorders
- ◆ Between 19- 42% of women with Cocaine dependence had concurrent PTSD (Falck et al., 2004; Back et al., 2000)
- ◆ Back et al. found that women with alcohol dependence and PTSD had more accident-related events
- ◆ In a large data analysis, women with co-morbid alcohol and cocaine dependence experienced significantly more traumatic events and had a higher prevalence of violent events and PTSD (Johnson et al., 2010)

Medical concerns

- ◆ Patients who abuse substances such as meth and alcohol weaken their immune systems
- ◆ See more respiratory and GI flu and viruses
- ◆ See more HIV, Hep C
- ◆ Some research suggests that the impact of a given amount of smoking on lung cancer risk may be greater among women than men, and that exposure to environmental tobacco smoke may be associated with increased risk for breast cancer
- ◆ In my practice, seeing breast cancer in their 20's, hyperthyroidism, lupus in their 30s.

Trauma Informed Care: Basic Assumptions

(Saakvitne, et al., 2000)

1. Symptoms are adaptations.
2. Trauma shapes the survivor's basic beliefs about identity, world view, and spirituality or meaning-making.
3. Using a trauma framework, the effects of trauma *can* be addressed within mental health and substance abuse treatment systems.
4. When worker and client share a trauma perspective, they can collaborate.
5. Use the framework of: *Respect, Information, Connection, and Hope (RICH)*.

A Trauma-Informed Framework Emphasizes
RICH Relationships
(Saakvitne, et al., 2000):

- ▣ **Respect:** Validate survivor experiences; reduce shame; place priority on safety, choice and control; emphasize resiliency in human responses to stress
- ▣ **Information: INQUIRE & LISTEN;** Provide resources; support consumer empowerment & skill development
- ▣ **Connection:** Healing power of relationships and being connected to others; open & collaborative
- ▣ **Hope:** For consumers and workers alike

PTSD vs. Complex Trauma

- ◆ **PTSD** typically develops from one incident, often experienced as an adult. "Single blow."
 - ◆ Three clusters of symptoms
- ◆ **Complex Trauma** is associated with repeated/recurrent incidents (e.g., domestic violence, ongoing childhood abuse, torture, war, homelessness).
 - ◆ Seven clusters of symptoms

Why Trauma-Informed Care in Substance Care?

Misunderstood or ignored signs of trauma may:

- Interfere with care delivery
- Limit engagement into services
- Lead to early drop out
- Inadvertently re-traumatize people we are trying to help
- Failure to make appropriate referrals

Trauma-Informed Care

- ▣ We **assume** that all people with whom we work have experienced and survived trauma, to avoid inadvertently or unnecessarily re-traumatizing them.
- ▣ We **acknowledge** that trauma comes in many forms.
- ▣ We **recognize** that the experience of trauma can impact how people think about and respond to themselves, events, people, and circumstances.

Language Matters: Trauma-Informed Statements

- ◆ Word choice communicates feelings and value
 - ◆ labels vs. descriptions
 - ◆ behavior vs. identity
 - ◆ circumstance vs. person
 - ◆ victim vs. survivor
- ◆ **What happened** to you vs. *what's* wrong with you?

A Trauma-Informed Approach Means:

- ◆ Completing a trauma screening or assessment as you are assessing for psychiatric and substance issues
- ◆ Developing treatment plans with trauma history in mind so that re-traumatization is kept to a minimum
- ◆ Recognizing and respecting when a person is not ready to discuss trauma experiences
- ◆ Treating trauma IS part of the work we do in substance treatment for children/adolescents/adults, in particular, women

Treatment issues

- ◆ Complex presentations often mean that we treat symptoms and not disorders
- ◆ Need to evaluate and treat the patient AND her children for trauma
- ◆ Need to evaluate medical issues and get basic blood work and physicals
- ◆ Often spend time helping get access to care for women and their children, medical, psych, and substance treatment

Angie

- Is this withdrawal, bipolar, MDD, PTSD or a medical issue going on??
- Getting basic labs and a physical
- Individual therapy focusing on trauma, coping skills other than substances, how to live in a substance-free world, assisting HER to change her perceptions of the world
- Family therapy a MUST if this family is to succeed
- WAITING and WATCHING symptoms
- Often treating with gabapentin (off label), SSRIs, lamotrigine, sometimes antipsychotics
- Referrals for the children for developmental evaluations, for therapy for older child, medical follow-up, psychiatric follow-up for long-term treatment of PTSD for the children

Problems with medications

- ◆ Their bodies can either metabolize quickly or they get strange side effects and different treatment effects depending on the drugs/chemicals in their bodies
- ◆ Is it too risky to start lamotrigine if they won't/can't get psychiatric care?
- ◆ Significant risk of NMS if antipsychotics used with meth

Buprenorphine as an option? (Unger et al., 2010)

- ◆ Women have a higher risk of developing a long QT syndrome (LQTS) because of the effect of the reproductive hormones on the electrophysiological structure of the heart
- ◆ Buprenorphine treatment during pregnancy seems not to be associated with greater risk to the mother or embryo/fetus than treatment with methadone other than a higher risk of withdrawal
- ◆ both methadone and buprenorphine are classified as FDA pregnancy category C medications (not enough data)
- ◆ Intrauterine exposure to opioids or other psychopharmacological medications can produce Neonatal Abstinence Syndrome (NAS) in the neonate in the first hours and days after delivery
- ◆ Signs of NAS are usually related to the central nervous system, autonomic nervous system, gastrointestinal tract, and respiratory system.

We share a sacred journey with our patients.

“We are reminded that the work has inevitable benefits and challenges, that we are stewards not just of those who allow us into their lives but of our own capacity to be helpful, and that a mindful and connected journey, both internally and externally, allows us to sustain our work” (Conte in van Dernoot Lipsky & Burk, 2009, p. xiii).

THANK YOU!!!
