Psychiatric co-morbidity among women with substance use disorders

Epidemiological and clinical studies have described a high co-occurrence of substance use disorders (SUD) and other psychiatric disorders, known as “dual diagnosis” (Torrens et al., n.d.; Kingston et al., 2017). These patients with a dual diagnosis are reported to have more emergency admissions, higher prevalence of suicide, increased rates of medical co-morbidity, more risk of relapse in drug use and psychiatric disorder, higher unemployment and homelessness rates and greater incident of violent or criminal behaviour (Greenberg and Rosenheck, 2014; Krausz et al., 2013; Martin-Santos et al., 2006). This dual diagnosis group of patients show poorer treatment outcomes, more clinical and social severity compared with patients with only one disorder, resulting in a high cost to the society (Krausz et al., 2013).

Although SUD is more frequent among males than females, the likelihood of having a comorbid psychiatric disorder is twice as high among women (Torrens et al., 2011). Among the drug-dependent women, dual diagnosis prevalence ranges between 15 and 100 per cent (Frem et al., 2017). Mood, anxiety (including post traumatic stress disorder), eating and borderline personality disorders are the most prevalent disorders, and also more frequent in females in comparison to men (Torrens et al., n.d.; Frem et al., 2017).

Research taking a gendered perspective among patients with coexisting SUD and psychiatric disorders has been growing during the last two decades, but little is known about the mechanism that mediates gender differences (Torrens et al., 2011). A number of potential risk factors may explain this higher psychiatric comorbidity: women with SUD have shown higher genetic vulnerability, more psychiatric disorders in their family history or higher environmental stress that may result in an increased experience of family disruption (Kuehner, 2017). Among these factors, women who are drug dependent are frequently involved in intimate relationships with drug using partners and may support their habits through sex trading and prostitution more frequently than men (Gilchrist et al., 2015). In addition, intimate partner violence (IPV) is highly prevalent among women seeking treatment for a SUD (Gilchrist et al., 2015; Kuehner, 2017; Weaver et al., 2015). The rates of IPV are higher among women who use drugs (25-57 per cent) compared to women who do not (8-16 per cent) (El-Bassel et al., 2011). A meta-analysis of longitudinal studies found a bidirectional relationship between SUD, alcohol in particular, and IPV victimization (Devries et al., 2014). When a SUD is co-occurring with depression or a PTSD, women are more vulnerable to experiencing IPV, less able to detect signs that lead to episodes of violence and less likely to access resources that may improve safety (Farré et al., 2017; Iverson et al., 2013; Weaver et al., 2015). IPV experiences are associated with sexual and injecting risk behaviours such as, less use of condoms, sharing injecting equipment and having multiple sexual partners, which are associated with an increased risk of blood-borne viruses (e.g. HIV and Hepatitis C) and sexually acquired infections. Furthermore, women who use drugs and are suffering IPV are more likely to continue using drugs and have more relapse as a result (Campbell et al., 2008; Weaver et al., 2015). A high rate of co-morbid psychiatric disorders and IPV has also been described among women who inject drugs (Tirado-Munoz et al., 2017).

In comparison to opioid-dependent men, women with opioid use disorder are more likely to be younger, victims of emotional, physical or sexual abuse, and tend to have high rates of psychiatric co-morbidity and multiple SUDs together with complicated social and family dimensions (Green et al., 2009), all of which can impede recovery.
Some additional gender-specific determinants that can influence the expression of dual disorders should be taken into account, like gender inequalities in social circumstances, a greater likelihood of living in poverty among women, the need to combine family responsibilities with work, education, stigma attached to substance use among women, higher risk of victimisation and social expectations for women (Stewart, 2007).

Furthermore, the prevalence of psychiatric co-morbidity among pregnant women who use substances is also significant, varying from 57 to 91 per cent (Coleman-Cowger, 2012; Strengell et al., 2015). Postpartum mood disorders affect approximately 10-20 per cent of women and this prevalence increases among women with lifetime substance use (Prevatt et al., 2017).

In short, women with SUD present more psychiatric co-morbidity than men with SUD and women without SUD; the most frequent psychiatric disorders being depression, anxiety and PTSD. They also have a greater risk of suffering IPV and report more sexual and injecting risk behaviours associated with HIV and HCV infection. These particularities have an impact on both disorders in terms of response to treatment and quality of life; therefore, psychiatric comorbidity among women seeking treatment for their SUD, should be specifically addressed. Policy makers must guarantee the access and appropriate treatment to women with SUD and comorbid psychiatric disorders.

Since the 1990s, a proliferation of gender-sensitive programs have been developed that focus on gender-specific needs, such as caretaking roles, IPV and trauma, risk behaviours, reasons for relapse and co-occurring psychiatric disorders. Additional research is needed to develop and test effective substance abuse treatment interventions for subgroups of women taking into account the diversity of socioeconomic circumstances, cultural background, substances of abuse, family status, risk factors and clinical and psychiatric comorbidities (Greenfield and Grella, 2009). Finally, future studies should explore the underlying genetic, psychosocial and environmental factors that are influencing the development of dual disorder, and possibly underlie gender specificity.

References


