Invited Commentary

Invited Commentary: Co-occurring Health Conditions Among Women Living With Profound Life Challenges

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People challenged by homelessness are living with several losses including the loss of a home, employment, economic security, health or well-being, and personal security. Assistance programs for people who are homeless consist of housing, emergency shelter, food services, employment assistance, peer support, medical care, and mental health services. An article by Riley et al. (Am J Epidemiol. 2011;175(5):515–522) appearing in this issue of the Journal examines the relation between basic subsistence needs and health outcomes in a cohort of 129 human immunodeficiency virus-infected women who were recruited from a probability sample of low-income hotels, homeless shelters, and free food programs in San Francisco, California. The results of their study underscore the importance of addressing subsistence needs and providing access to medical and psychological treatment for homeless and unstably housed women. In addition to subsistence needs, more attention should be given to comorbid psychiatric and medical conditions that occur among homeless women, including trauma-related disorders.

acquired immunodeficiency syndrome; comorbidity; homeless persons; poverty; substance-related disorders; veterans health; women

Abbreviation: PTSD, post-traumatic stress disorder.

In the United States, many people suffer from comorbid substance abuse and other medical and psychiatric disorders, and this is true of many homeless persons (1). Of course, homeless populations are very heterogeneous, and many people who transition in and out of homelessness do not suffer from substance abuse or dependence or other serious mental illness. They may face other profound life challenges, however. For people who are homeless, assistance programs consist of housing, emergency shelter, food services, employment assistance, peer support, medical care, and mental health services including those aimed at recovery from substance-related disorders (1, 2). Such programs are administered by a variety of federal and state agencies, nongovernmental organizations, faith-based organizations, and veteran service organizations (2, 3).

An article by Riley et al. (4) appearing in this issue of the Journal examines the relation between basic subsistence needs and health outcomes in a cohort of 129 human immunodeficiency virus-infected women in San Francisco, California, who were homeless or unstably housed. At least 15% of the women were veterans, and most (97%) reported some form of health insurance coverage (4). The women were recruited from a probability sample of low-income hotels, homeless shelters, and free food programs. At baseline, 33% of the respondents reported cocaine use, and 20% reported sleeping on the street or in a homeless shelter during the past 3 months. About 25% had unmet subsistence needs, defined by the authors as difficulty gaining access to a bathroom, place to wash, clothing, food, or place to sleep, regardless of where the respondent slept (4). Unmet subsistence needs were an important predictor of overall mental health, physical health, and gynecologic symptoms (4). The results of their study underscore the importance of addressing subsistence needs and providing access to medical and
Psychiatric disorders that may co-occur with substance abuse and dependence include major depression and anxiety disorders, such as generalized anxiety disorder and post-traumatic stress disorder (PTSD). Traumatic events, which include the trauma of losing one’s home or being diagnosed with a potentially life-threatening illness, can lead to several anxiety and mood disorders including major depression and PTSD. People challenged by homelessness are living with several losses including the loss of a home, employment, economic security, health or well-being, privacy, and personal security (1). It would be useful to know how many of the women in the study by Riley et al. had experienced physical trauma, such as assault or adult sexual abuse, to better understand the life challenges faced by the research participants and because the models used in the study assume that there were no unmeasured confounders related to health status. The co-occurrence of major depressive disorder and PTSD has been observed in population surveys (5, 6) and women who were the victim of intimate partner violence (7–9). Major depressive disorder occurs frequently, by itself or concurrently with PTSD, after traumatic exposures (10).

Clinical and epidemiologic studies have shown that substance dependence and abuse are strongly related to PTSD (11–13). Studies of cocaine-dependent or opioid-dependent patients (e.g., those in methadone treatment programs) have found a lifetime prevalence of PTSD in the range of 10%–30% (14). Histories of significant trauma and PTSD are common among patients in treatment programs for substance dependence (14). Alcohol use disorders and other substance use disorders are frequently seen among patients seen for treatment of PTSD (15). The co-occurrence of substance abuse and dependence and other psychiatric disorders is partly due to shared risk factors and the fact that adverse life events and other exposures can lead to more than 1 condition in the same individual. Persons with major depressive disorder and certain other psychiatric disorders may have greater vulnerability to developing PTSD following a traumatic event, which can also contribute to comorbidity (16, 17).

Women are more likely than men to be exposed to sexual assault and chronic forms of interpersonal violence, such as domestic violence or battering (18). Both PTSD and problem drinking are frequently observed among survivors of sexual assault, which has prompted researchers to examine whether survivors drink to cope with PTSD symptoms or whether PTSD symptoms are made worse by heavy drinking (19).

Epidemiologic studies have suggested that persons who use illicit substances are more likely to be exposed to traumatic events and to develop trauma-related disorders. In the St. Louis Epidemiologic Catchment Area Study (12), respondents who indicated that they used cocaine or opiates were almost twice as likely as comparison subjects to report a traumatic event (odds ratio = 1.8, 95% confidence interval: 1.5, 2.3) and were more likely to meet diagnostic criteria for PTSD. Physical attack was the most frequent traumatic event reported among cocaine/opiate users (12). Persons with PTSD may be relatively susceptible to alcohol or opiate abuse or dependence because of the reduction in hypervigilance symptoms that these substances afford (20).

Jacobsen et al. (15) noted that results from published studies generally support a pathway whereby PTSD precedes substance abuse or dependence. Persons with PTSD may initially use substances to modify their symptoms. According to this “self-medication” hypothesis, persons with PTSD may use psychoactive substances to alleviate their traumatic memories and other painful symptoms. Following the development of drug or alcohol dependence, they may then experience distressing physiologic and psychological symptoms resulting from substance withdrawal (e.g., arousal symptoms that exacerbate PTSD symptoms) that contribute to a relapse of substance use (15). Alternative pathways may also account for linkages between PTSD and substance abuse or dependence. Some substance abusers may repeatedly place themselves in dangerous situations and, consequently, be exposed to physical violence or other traumatic experiences in the course of using or procuring illicit drugs or alcohol (15).

The co-occurrence of major depressive disorder, PTSD, or other mental disorders has been associated with poorer prognosis, greater duration and severity of illness, poorer treatment response, and higher suicide risk (21). Although there is a need to avoid unnecessary “labeling” of people and inadvertently contributing to the burden of mental illness, scientific studies of psychiatric comorbidity contribute to the improvement of diagnostic classification systems over time, identify possible opportunities for prevention and early intervention, and help to ensure that people have access to safe and effective evidence-based treatments.


