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Gender Perspective and Women Drug Users: Specific Needs in Relation to Substance Use Treatments

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Abstract: Women under treatment are a particular susceptibility group according to the classification of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The average number of women under treatment is lower than men all across Europe, and the drop-out percentage is higher in women than men. The aim of this study was to investigate the factors associated with drug use problems among women under treatment. Methodology: Quantitative research. Data from 2179 people receiving recovery treatment were extracted from EuropASI surveys. The dependent variables in this study were (1) the patient's family history of addiction and psychiatric disease, (2) the main substance consumed, (3) the lifelong and last month's substance use, (4) the lifelong and last month's emotional, physical and sexual abuse, and (5) the lifelong and last month's psychiatric disorders (including suicide attempts). The factor was gender, taken as a dichotomous variable (male–female). Initially, the Kolmogorov–Smirnoff normality test and Levene's test were used to understand whether the sample met the normality and homoscedasticity statistical assumptions. For quantitative variables, the Mann–Whitney U test was used. The confidence interval used was 95%. Results: Briefly, we found that women tend to consume more alcohol, use more medication, and suffer more depression, anxiety and suicidal ideation than men, both lifelong and in the last month. In addition, women suffer more abuses (emotional, physical, and sexual) than men, during their lifetime and in the last month. Conclusions: The data showed that women have specific needs and vulnerabilities that should be accounted for when providing treatment but are currently not. This situation evidences the need for specialized drug recovery programs for women, and not only that, programs must adapt to the needs of each woman's particular situation. Moreover, it is pressing that a multifactorial approach is used in every intervention, given the multiplicity of factors influencing consumption and the evidence that fixed treatment programs are not satisfactorily intervening in the complex reality that surrounds people with addiction.

Keywords: gender perspective; multifactorial perspective; social and health responses; women under addiction treatment; psychological and social factors

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1. Introduction

Addiction is a multifactorial problem, which involves different biological, psychological and social factors as causes and consequences. There is a perspective that addressing the risks and problems associated with substance use disorders (SUDs) that requires looking at the population as an homogeneous group and treating gender primarily as a neutral component. Some models assume that women's drug use lacks unique characteristics and assign the same explanations (and intervention strategies) to men and women [1,2].

According to estimates, over 30 million women and 50 million men between the ages of 15 and 64 in the European Union have tried illegal drugs at some point in their lives [3]. Overall, the gender gap in total drug use among young people is smaller, and the gap between younger age groups appears to be narrowing in many European countries [3]. Women account for 20% of requests for drug addiction treatment all across Europe [3]. Consequently, most substance misuse intervention programs are created when thinking about men under treatment, disregarding the unique needs of women [1,2]. Epidemiology statistics [3,4] demonstrate that women are less likely to seek therapy to overcome SUDs than men and that they also progress less favorably after using the services. It appears that starting addiction treatment is more difficult for women than it is for men because women usually have less family and social support, face gender-based expectations to care for their families and children, and worry about the consequences of their addiction because, if made public, it would lead to the loss of custody [5]. Also, because most residential-type services (e.g., therapeutic communities) normally do not allow access to children, the facilities are not adapted to them or limit regular contact with their children [6].

There is also a view that addressing the risks and problems associated with problem drug use requires looking at the population as a whole, predominantly treating men as a neutral component. Some models assume that women's drug use does not have different patterns than men's use, leading to men and women having same explanations and intervention strategies [1]. In this sense, harm reduction and recovery-based programs are social and health interventions for addiction that lead to gender-neutral interventions [2].

As addiction has different characteristics in men and women due to biological variations, as well as social and cultural differences resulting from gender socialization, intervention tactics and activities must be tailored to these variations [2]. Studies showed that women have a less positive treatment outcomes than men, partly because these programs and services are not created with consideration of the unique needs of women [3], and consequently face more pressure to leave the programs early from their surroundings, families, and social groups.

Even though Europe has both private and public resources, female users do not access the services to the same extent as male users, which is made more difficult by the fact that the few women who do manage to overcome access barriers tend to drop out of programs more frequently and experience less therapeutic success [4]. In this way, the programs designed and implemented are not effective due to their inability to support women in treatment and meet the proposed long-term objectives [7]. Currently, several authors have identified barriers to the criminalization of women drug users in the context of the war on drugs [7–11]. Also, some authors have highlighted the lack of a gender perspective in drug services [8,12–16]. The lack of a gender perspective in drug addiction treatment and services has two obvious consequences. The first is the invisibility of women drug users, which leads to failure to consider women's specific circumstances and needs, which means women are hurt or re-victimized by the drug services [13,15,16]. The overwhelming majority of studies on the treatment of drug addiction have shown that services adapted to the needs of women and people of other gender expressions and identities are not provided [6–8], which has prompted international monographic reports [5] on the treatment of drug problems to suggest and guide differential interventions that are should be more effective. The gender-mainstreaming approach to drugs research and intervention means taking into account gender differences and specificities in the factors that determine the different motivations, patterns, effects and consequences of drug use [9]. It also means addressing gender gaps or inequalities in access to care in order to improve adherence to care and reduce dropout rates [1,6,7].

Right now, there is broad agreement that considering the mutual influence of diverse determinants is essential to achieving improved public health outcomes [2], such as expanding access to healthcare for underprivileged groups [9–12]. The causes of inequality can be specifically understood by describing how the intersection of various social identities (racial/ethnic minorities, women) and the structural inequalities associated with these iden-

tities (racism, sexism) influence lived experiences (especially access to care) [13], thereby perpetuating disparities in the excluded group [9–12,14].

Furthermore, gender differences in life experiences (e.g., work choices and family responsibilities) play a major role in changes in health outcomes, such as higher mortality in men and higher morbidity in women [15]. When women seek help for drug or alcohol use, gender-based violence affects them more than women in general [4,16–19]. Research and practical experience show that drug use and addiction are multifactorial syndromes (social, genetic, family, educational, emotional factors, etc.) that interact: physical and/or sexual abuse predisposes a person to drug addiction, addiction predisposes people to addiction. The presence of both problems often leads to more severe medical problems, social and family isolation, financial dependence, and, most importantly, increased family responsibilities, which create significant barriers to accessing and sustaining treatment [16–18].

The concept of recovery [18,19] is really important regarding the treatment and rehabilitation of addictive behaviors. Recovery is significant because the aim is not merely reducing or eliminating the use of drugs (including alcohol) [20,21] but also becoming an active member of society [18,20,21]. This study, conducted in a sample of people who are under SUD recovery treatment (outpatient and residential facilities, with pharmacotherapy, psychotherapy and psychosocial intervention programs), aims to investigate the factors associated with drug use problems in women in treatment, taking into account various psychological and social factors (gender, drug use, mental health, sources of financial support, legal status, and sexual and domestic violence). The hypothesis is that women under SUD treatment present different vulnerabilities compared to men, which are not taken into account by these interventions. This would be achieved by examining the differences between women and men in terms of the psychosocial factors that influence (and are influenced by) drug use.

2. Materials and Methods

2.1. Participants and Procedures

This study used exploratory analysis. Data on 2173 people receiving rehabilitation treatment were collected through the EuropASI survey and extracted from the PH Nemos (Proyecto Hombre survey repository) and Minerva (Dianova survey repository) databases, ensuring that all the participants in the databases were included and analyzed together. The sample consisted of 1850 males and 323 females, accounting for 83.1% and 14.5% of the sample, respectively. Contingency tables were used to relate the categorical variables to the factor of gender. Data were collected from the participants in personal interviews by trained professionals. Written informed consent was obtained from all the participants and confidentiality and anonymity were guaranteed. Approval from the UCM Deontological Research Commission was received, with the ethical approved project identification code UCM PR2019_20_043.

2.2. Tools and Instruments

EuropASI is the European version of the Addiction Severity Index (ASI), fifth edition, developed in the USA by McLellan in 1990 [22]. It is intended to assist in treatment planning and/or referral decisions and may also be used in research [23].

Drug use was recorded as the number of years of life in which respondents reported having used at least one dose of the drug. "Family history of addiction" data were collected from the sections "Family History" and "Family relations". From "Family relations" were also extracted the response to the abuse items (emotional, physical and sexual abuse).

"Mental Health" data were collected from the block of "Psychiatric situation". "Abuse" data were collected from the section "Family and social relations".

Finally, "gender" was coded as female = 1 and male = 2; and "age" was coded as the actual number of years.

2.3. Data Analysis Plan

The dependent variables in this study were (1) the patient's family history of addiction and mental health, (2) the main substance consumed, (3) the lifelong and last month's substance use, (4) the lifelong and last month's emotional, physical and sexual abuse, and (5) the lifelong and last month's mental health (including suicide attempts), The factor was gender, taken as a dichotomous variable (male–female).

First, the Kolmogorov–Smirnoff normality test and Levene's test were used to understand whether the sample met the statistical assumptions of normality and homoscedasticity. If these assumptions were not met, non-parametric tests were used for analysis. Initially, to understand whether there were gender differences in the various dependent variables, a hypothesized comparative analysis was conducted using contingency tables for categorical variables and the Mann–Whitney U test for quantitative variables. The confidence interval used was 95%. The adjusted standardized residuals were used for interpretation (residual values less than −1.96 or greater than 1.96, respectively, indicate a lower or higher number of cases than expected under the null hypothesis). All these analyses were performed using SPSS Statistics v27.0.

The percentage of missing data is due to the fact that not all the participants completed all the items in the questionnaire.

3. Results

3.1. Demographic Characteristics of the Sample

The gender distribution was 84.7% male and 15.3% female. The average age was 37.91 years, ranging from 18 to 73 years. Moreover, 79.68% were of Spanish nationality, followed by a smaller number from other countries (Romania, Brazil, Germany, Ukraine, Bulgaria, Russia, Belgium and Venezuela). In addition, 46.91% of those treated were from cities with a population of over 100,000, 29.98% lived in cities with a population of 10,000–100,000, and 23.11% came from the countryside. In terms of the education level, 45.27% of people said they were "uneducated" (that is, people who have not started or completed primary education) and 29.93% said only "primary education", meaning that 75.20% of people had lower academic qualifications. The proportion of participants who reported media research was 17.13%. The least were those who obtained a first-cycle university degree or diploma (4.49%) or a second-cycle university or bachelor's degree (3.18%). There were no significant differences between men and women regarding the demographic characteristics.

3.2. The Patient's Family History of Addiction and Psychiatric Diseases

The most significant result was that more men had family members with an addiction (mainly alcohol problems) and a history of psychiatric disorders. The most significant differences were identified in the maternal grandfather (alcohol problems) ($p = 0.024$); the mother (alcohol problem) ($p < 0.001$), drug problems ($p = 0.05$) and psychiatric problems ($p = 0.013$); the maternal aunt with alcohol problems ($p = 0.02$) and psychiatric problems ($p = 0.004$); and the father with alcohol problems ($p = 0.038$) and psychiatric problems ($p < 0.001$).

3.3. Substance Use

When it comes to the principal substance of use, differences ($p = 0.012$) by gender were found in relation to alcohol (small and large volumes) and cocaine, as well as in not reporting problems with drugs (but with other addictive behaviors). In this regard, women tended to consume alcohol (small and large volumes) and men to consume cocaine and to report no problems (which means no use of substances but other addictive behaviors). Other differences were found in the lifelong consumption, with men consuming more cocaine ($p < 0.001$), cannabis ($p = 0.041$), hallucinogens ($p = 0.007$) and polyconsumption ($p = 0.001$) than women. There were no significant differences by gender in the last month's consumption (see Table 1).

Table 1. Association between gender and principal substance of use.

		Alcohol (Small Doses)	Alcohol (Large Doses)	Cocaine	No Problem
Men	**Count**	89	273	473	165
	% of the total	4.5%	13.8%	23.8%	8.3%
	Corrected residue	−2.2	−3.2	2.3	2.2
Women	**Count**	25	70	63	17
	% of the total	1.3%	3.5%	3.2%	0.9%
	Corrected residue	2.2	3.2	−2.3	−2.2

3.4. Psychiatric Disorders

Differences by gender showed that women reported more lifelong depression/mood disorders ($p < 0.001$), anxiety ($p < 0.001$), problems in understanding, concentrating or remembering ($p = 0.01$), use of medication ($p < 0.001$), suicidal ideation/tendencies ($p < 0.001$), suicide attempts ($p < 0.001$) and number of suicide attempts ($p < 0.001$) than men. These differences were also found in the last month's depression ($p < 0.001$), anxiety ($p < 0.001$), use of medication ($p < 0.001$) and suicidal ideation ($p = 0.025$) (see Table 2).

Table 2. Association between gender and last month's psychiatric disorders.

		Depression	Anxiety	Medication	Suicidal Ideation
Men	**Count**	363/1850	615	538	194
	% inside gender	21.8%	36.8%	32.3%	11.6%
	Corrected residue	−4.8	−5.6	−5.8	−2.2
Women	**Count**	100/323	156	144	47 *
	% inside gender	34.7%	54.2%	50.0%	16.3%
	Corrected residue	4.8	5.6	5.8	2.2

* The sum is higher than 323 because individuals have various conditions.

3.5. Abuse

Regarding the different types of abuse, data showed that women suffered more emotional ($p < 0.001$), physical ($p < 0.001$) and sexual abuse ($p < 0.001$) than men, both lifelong and in the last month too (see Table 3).

Table 3. Association between gender and lifelong abuse.

		Emotional Abuse	Physical Abuse	Sexual Abuse
Men	**Count**	633	332	66
	% inside gender	43.6%	23.0%	4.5%
	Corrected residue	−6.9	−8.8	−12.7
Women	**Count**	179	131	74
	% inside gender	66.3%	49.1%	27.6%
	Corrected residue	6.9	8.8	12.7

4. Discussion

Several previous studies have pointed to the need to consider a holistic approach to interventions for women with addiction, as addiction is part of a complex puzzle that must be taken into account in its entirety in order to carry out ethical, effective and social-justice-based treatments [1,6,17,18].

4.1. Gender and Drugs

The use of illegal drugs contributes to women who consume them being associated with a higher degree of complexity, chronicity, and worse prognosis [1,6,17,18]. Along this line, this research found that the consumption of illegal drugs, specifically cocaine, cannabis and hallucinogens, is actually more prominent in men than women, with women tending more toward alcoholism. This means that the more common profile of women with addictions is that of alcoholic women, not the one with addictions to other drugs [24]. Given the more permissive attitude toward alcohol in society in comparison to other drugs, the prejudice associated with women with addictions should be laxer as well; however, it is not [19]. The literature that analyzes from a gender perspective why women consume legal substances has to do with the mandate for prudence and non-transgression, unlike men [8]. This leads to less identification of their problematic consumption, their cases becoming more chronic, and their treatment management being, apparently, more complex [25]. There are certain stereotypes associated with women with addictions [23], such as that they have less motivation to carry out therapeutic itineraries or that they tend to generate more acute and chronic addiction processes compared to men [6,8,9]. This belief has an impact on the internalized stigma [26], generating negative self-efficacy expectations that create a huge barrier when it comes to recovery [2–5,20]. Thus, addressing the gap between the reality of women with addictions and the social view of them is important in order to destigmatize them [13,26], as well as to provide data-driven interventions that fit their actual needs [20,21,26].

Women with addiction problems lack social support to a greater extent than men due to the double stigma and social penalization. This, in combination with the economic difficulties that are so prevalent in the drug-dependent population, can generate situations of extreme vulnerability such as homelessness. The experience of homeless women is devastating, facing constant threats, assaults and, above all, sexual and police violence. The situations that are generated by the purchase of drugs seem to be particularly dangerous and there is a high risk of sexual violence, as reported by our participants [15,16,26].

When intervening in the treatment of addiction, the complex reality of drug use must be viewed from a multifactorial perspective [20,21]. This is why all the factors that influence, and are influenced by, addiction have to be accounted for and studied in order to intervene in them as well. The factors analyzed in this research are psychiatric disease and abuse [19].

4.2. Gender, Drugs, and Psychiatric Disease

In this research, it was found that women tend to have more psychiatric diseases and mental health problems than men, both throughout life and during treatment. This is relevant since, even though some aspects of mental health do improve during treatment (such as the problems concentrating and the suicide attempts), others do not, which implies that treatments do not tackle this issue [9,22]. The present research was focused on the past month for psychiatric conditions to detect the situation in the moment and to decrease the bias because of the overdiagnosis suffered by women with substance use. This is one of the main problems: women receive more diagnoses and sometimes that is not conducive to treatments [16,17,19]. Furthermore, it could be argued that suicide attempts decrease because the treatment context keeps patients under monitored conditions that do not allow for these attempts to take place [6,21]. This can be supported by the findings that suicidal ideation keeps being a problem for women even as they are receiving treatment [6,7,21]. Different studies demonstrated, in the same way, that women usually suffer more mental health problems than men, showing the need for treatment to focus on this issue when dealing with women with addiction. Also, it seems necessary to design these treatments and to do so in a different way than it is applied for men, since it affects women in a different and more severe manner [6,9,11,21,22].

4.3. Gender, Drugs and Abuse

Finally, it was found that women with addictions experience more emotional, physical, and sexual abuse than men [19,20,22]. The prevalence of gender violence in the sphere of the couple and sexual violence experienced by women drug users is overwhelming. The impact that violence has on mental health is directly related to consumption motivations as a coping style, which in turn reduces the ability to react and hinders recovery from both violence and addictions. The stories of the women survivors of violence who participated in this research reveal the deep relationship between violent experiences, traumas throughout their biography and the need to consider everything together to carry out appropriate therapeutic interventions [15,19–22], with the consequences for mental health that entails, but also during treatment, which hinders its effectiveness and hampers recovery.

As noted by Cohen et al. (2006), prior research has demonstrated a strong association between exposure to trauma (sexual, physical assault, or both) [24] and substance use disorders in women [6,9,11,20–23]. It is important to develop the idea of Benoit (2016) that there is a higher prevalence of trauma and violence in the population with substance use disorders vs. the general population [21]. Furthermore, there is enough evidence that we can find a higher prevalence of trauma and violence in women with SUDs than in men with SUDs. This factor may explain how the gender variable is basic to understanding the relevance of trauma and violence interventions for women under treatment and how addiction moderates and amplifies this vulnerability and those inequalities [6,9,11,19–23,25,26]. Moreover, the impact that violence has on mental health is directly related to consumption as a coping style [6,9,11,20–22].

4.4. Limitations of This Study

The first limitation is the number of missing data, which can be explained by the personal nature of most of the questions in the questionnaire and the reluctance to answer this might lead to. Since the sample size is big, the amount of missing data does not imply a drastic reduction of the sample; however, it does indicate that questions remain unanswered, which can influence interpretations and generalizations. While corrections are intended to control the risk of false positives (type I errors), overly conservative methods like Bonferroni may lead to the rejection of real and meaningful effects. Some researchers argue that applying corrections like the Bonferroni method across multiple dependent variables can be too conservative [27]. Over-correction can increase the likelihood of type II errors, meaning that true effects may be missed. This is especially problematic when the dependent variables are correlated because treating them as independent in a correction method like Bonferroni might underestimate the true relationships [27]. Furthermore, we agree with other authors (e.g., Perneger, 1998) that the rationale for the Bonferroni correction disappears when there is one independent variable and multiple dependent variables [27]. A result with, say, $p = 0.045$, derived from a single comparison between men and women on a certain dependent variable, would be interpreted as statistically significant, even if there were ten other outcomes recorded in the data file that had not been analyzed. However, that same comparison would no longer be considered significant if we analyzed any other outcome. For all the reasons mentioned above, we did not apply corrections in the analyses in this study.

Secondly, the sample is composed of more men than women, which is to be expected as there are more men with addictions than women. Still, future studies could try to balance the number of men and women compared. Such an imbalance will make the larger sample have a greater influence on the pooled variance estimate. This can bias the results and lead to a decrease in statistical power compared to the same number of subjects divided into equal-sized groups [8,28,29]. However, the current distribution is globally better than a sample of only 646 subjects divided into two equal groups of 323. These types of imbalances are deliberately sought, for example, in case-control designs, where cases are difficult to recruit and controls are easily available, establishing a case/control ratio (sometimes including more than five controls per case, Hennessy et al., 1999) [30]. In terms of our study subjects, we will always find a larger number of male subjects than

female subjects. Specifically, using a two-tailed Mann–Whitney test, an alpha = 0.05, and assuming an effect size d = 0.2, two equal groups with n = 323 would lead to a power of 1 − beta = 0.698. In contrast, with one group of 1850 and another of 323, the power increases to 1 − beta = 0.900 (we used G*Power version 3.1.9.7 for these calculations) [29]. Another risk of groups with different sizes, that of biased parameter estimation, also does not occur in the non-parametric Mann–Whitney test, which is robust in these cases. Unequal sample sizes mean that the larger group will contribute more ranks, but this does not inherently bias the test results. The test is sensitive to differences in the median as a measure of the central tendency, and this is also not affected by the inequality in sample sizes. Some of these ideas can be found in Bürkner et al. [28]. On the other hand, the choice of exploratory analyses (even when we use hypothesis testing to reach conclusions about the population) is not arbitrary. There is no other option when the data have been obtained from a cross-sectional design using databases. Under these conditions (and in the vast majority of applied scenarios in the field of substance use), it is not possible to design an explanatory study. The intrinsic lack of control over the gender factor prevents any causal objectives. The choice of variables is determined by the available data, and the results aim to provoke reflection rather than to determine a theoretical model.

Another limitation is the absence of participants from the LGBTIQ community. There is evidence that treatments for women, non-binary people, LGBTIQ people, etc. are not therapeutically effective, which contradicts the ideal of universal access, but it is worth exploring this topic in depth in another study. This is a future direction of this topic.

A very relevant limitation is that this is a sample of individuals already in treatment, so our findings do not directly explain what prevents women from entering treatment. We can infer several issues. In our next studies, we would go deeper into the topic, but it is not possible to conclude in this direction with the data, the sample and the analysis of the actual study.

Finally, the data analysis conducted shows there are significant differences and shows the direction of these differences, but not the underlying causes for them. Future research should stem from these data to inquire into the causes of these differences in order to develop a more exhaustive framework on the risk and protection factors for addiction, both for men and for women.

5. Conclusions

This research aimed to investigate the factors associated with drug use problems in women in treatment, taking into account various psychological and social factors (gender, drug use, mental health and sexual and domestic violence) from a multifactorial analysis [20,22,23,25]. The data showed that women have specific needs and vulnerabilities that should be accounted for when receiving treatment but actually are not [5,23,26,31]. This situation evidences the need for specialized drug recovery programs for women, and not only that, programs must adapt to the needs of each woman's particular situation [23,26,31]. Moreover, it is pressing that a multifactorial approach is used in every intervention, given the multiplicity of factors that have an influence on substance consumption and the evidence that actual treatment programs are not satisfactorily intervening in the complex reality that surrounds people with addiction [31]. Future lines of research should focus on how we can understand and improve women's entry to treatment, and the way to decrease dropouts or decisions to leave treatment [31]. Another future line has to be how to modify substance use treatment for gender-tailored treatment, analyzing the reasons behind gender differences in mental health, abuse and social support, as well as the different reasons why men and women use drugs and other addictive behaviors [20,21,26,31].

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Data Availability Statement: The data presented in this study are available on request from the corresponding author.

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