

Women and Substance Use

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Substance Use and Abuse among U.S. Women

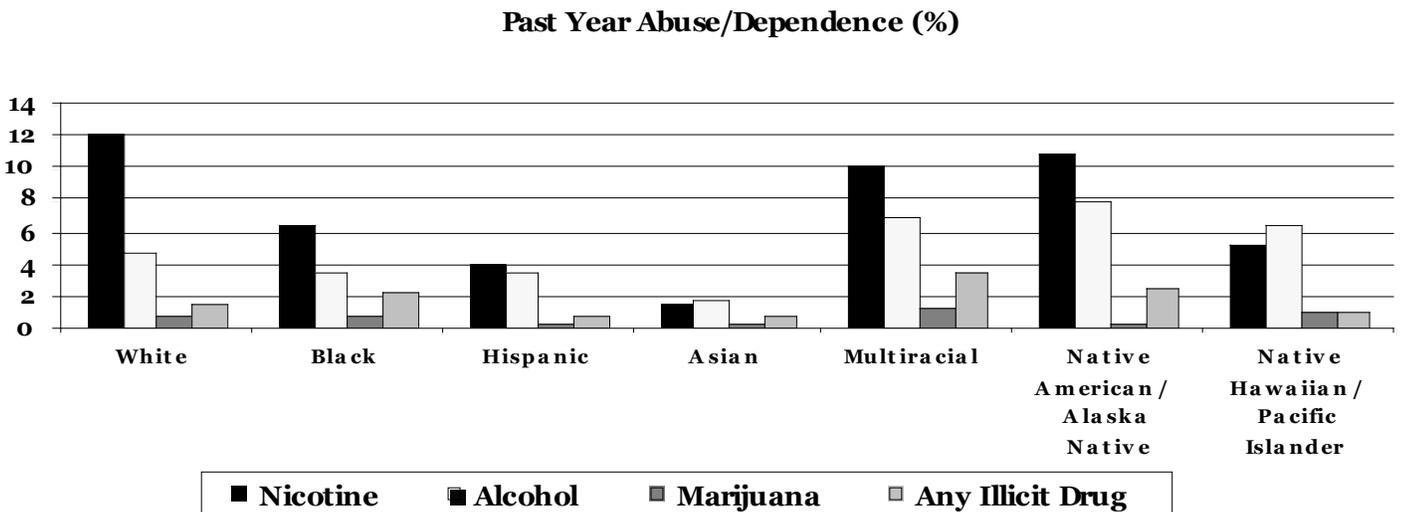
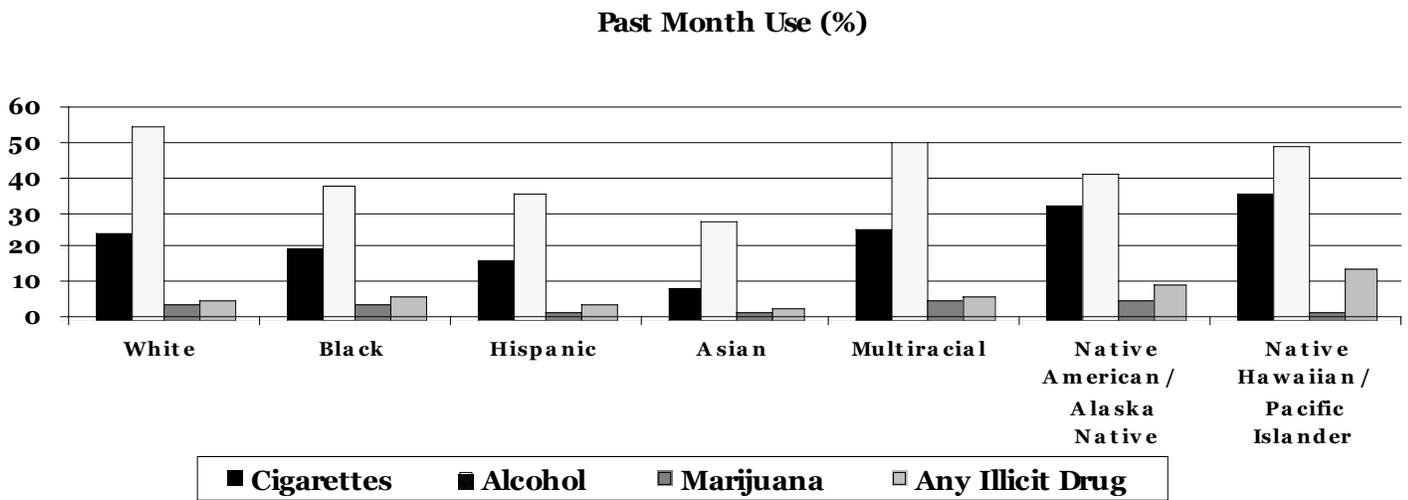
- Research and policy attention on women and substance use has been historically dominated by a narrative of “pathology and powerlessness” that reduces women to either villains or victims—morally depraved women who fail to perform feminine roles (e.g., related to motherhood), or dependent and powerless victims trapped in a life of addiction.¹ This disempowering narrative shifts focus away from structural conditions related to women’s lived experiences, and often perpetuates misperceptions about women who use substances.
- Results from national surveys show that less than half of U.S. women report any past month use of tobacco, alcohol, or other illicit drugs (see first row of Table 1).² Although most women who use substances do so only experimentally, or recreationally in the pursuit of leisure,¹ a small percentage of women can be classified as substance abusers (i.e., experiencing social, health, financial, legal, or other problems related to their substance use) or substance dependent (i.e., experiencing substance-related problems as well as symptoms of withdrawal/tolerance). For example, in 2007 7.7% of women age 12-17, and 5.5% of women age 18 and older met criteria for any substance abuse/dependence in the past year (see bottom row of Table 1 for breakout by type of substance).³

Table 1. Weighted Percentage of Women Reporting Any Past Month Substance Use Versus Past Year Substance Abuse/Dependence, by Age Group and Type of Substance: 2007 National Survey of Drug Use and Health²

	Age 12-17				Age 18 and Older			
	Cigarettes	Alcohol	Marijuana	Any Illicit Drug	Cigarettes	Alcohol	Marijuana	Any Illicit Drug
Any Past Month Use	9.7%	16.3%	5.9%	9.2%	22.6%	48.7%	3.6%	5.4%
Past Year Abuse/Dependence	2.7% (Nicotine)	5.7%	2.7%	4.3%	11.5% (Nicotine)	4.3%	0.7%	1.6%

- Women who use substances (particularly women who are pregnant or mothers) are often subject to a cultural double standard.⁴⁻⁵ This “stigma of the tainted woman” may date back to 19th century middle-class standards of morality associated with the cult of true womanhood, and likely represents a present-day aversion to women’s self-governance or gender nonconformity.⁶⁻⁷
- For instance, drug policy discourses often frame pregnant substance users as selfish, lazy, criminals who deserve neither the right to reproduce, nor the custody of their children.⁸ Substance abuse during pregnancy can indeed lead to serious fetal/neonatal health and behavioral problems (e.g., fetal alcohol syndrome, neonatal abstinence syndrome), but moral panics such as the “crack baby” panic often unnecessarily escalate public levels of fear and anxiety and scapegoat poor minority women.⁹ For instance, recent reviews challenge the widely held assumption that prenatal exposure to cocaine and low/moderate levels of alcohol have a detrimental influence on fetal/neonatal outcomes.¹⁰⁻¹¹ Rather, it appears that poverty and economic disadvantage, not substance use, play the largest role on fetal, neonatal, and childhood outcomes.^{10, 12} As such, these moral panics often serve to direct public attention toward individual level pathologies and away from structural inequities.
- Another misperception often perpetuated by the media is that women of color are the most likely to use and/or abuse substances. But, recent estimates from national surveys indicate that Black, Hispanic, and Asian women generally have lower prevalence estimates of both substance use and substance abuse/dependence than white, multiracial, Native American/Alaska Native, and Native Hawaiian/Pacific Islander women (see Figure 1).²

Figure 1. Weighted Percentage of Women Age 18 and Older Reporting Any Past Month Use Versus Past Year Substance Abuse/Dependence, by Type of Substance and Race/Ethnicity: 2007 National Survey of Drug Use and Health²



Women and Substance Abuse Treatment: Needs and Barriers

- Results from recent national surveys of treatment facilities indicate that women comprise approximately 32% of admissions to structured substance abuse treatment facilities, only 4% of whom are pregnant. These estimates refer to ambulatory, detoxification, residential, and medication-assisted opioid treatment facilities that generally receive state alcohol and drug/agency funds, rather than self-help programs (e.g., Alcoholics Anonymous) for which data are not consistently available. The most common primary substance at treatment admission for women is alcohol, followed by opiates, cocaine, stimulants, and marijuana.¹³
- Between 2004 and 2006, an estimated 6.3 million (9.4%) U.S. women between ages 18 - 49 needed treatment for substance abuse or dependence. Of these women, 5.5% perceived the need for treatment but did not receive treatment. Of those 345,000 women, the most common reasons cited for not receiving treatment were: not ready to stop using (36.1%), cost/health insurance barriers (34.4%), and social stigma (28.9%).¹⁴
- Stigma, labeling, and guilt are key barriers to treatment for many substance abusing women, who are subject to a cultural double standard that stigmatizes them for violating gendered expectations of behavior.¹⁵⁻¹⁷

- Many women who abuse substances have a history of sexual abuse, physical abuse, or trauma, and may abuse substances to self-medicate or cope with such traumatic life events.¹⁸⁻¹⁹ Women who are survivors of abuse or trauma may therefore need treatment program components that help them deal with these traumatic life events. Women-only treatment programs often report better client outcomes after treatment, perhaps because they provide safe spaces for women to explore issues related to histories of trauma.²⁰⁻²¹ Approximately 32% of substance abuse treatment facilities in the United States offer special programs or groups for adult women, and 5% for gays or lesbians.²²
- Women's substance abuse often co-occurs with mental illness, particularly anxiety, depression, bipolar disorder, eating disorders, and posttraumatic stress disorder. Thus, women may benefit from treatment components that address these comorbidities.^{4-5, 23-24}
- Pregnancy is another barrier to substance abuse treatment for women; some pregnant women report postponing or avoiding treatment for valid fear of losing custody of their children.^{17, 25-26} Many states consider substance use during pregnancy a form of child abuse, and some states require health care workers to report or drug test any pregnant mothers they suspect to be using drugs. These policies disproportionately affect poor minority women.²⁷⁻²⁸
- Many women do not receive, or at least postpone, substance abuse treatment because they do not have access to childcare.²⁹ Substance abuse treatment programs that provide childcare or allow women to live with their children often report higher treatment retention and better treatment outcomes.³⁰

Key Actions for Change

- Challenge sexist assumptions about gender nonconformity that unfairly stigmatize women—particularly pregnant women and mothers—who use or abuse substances.
- Shift research and policy attention away from individualized discourses that focus on women's individual level risk and pathology. Instead, reframe the issue in terms of structural barriers such as the poverty, racism, and gender oppression that contribute to the etiology of women's substance use and abuse.^{1, 31}
- Advocate for changes in current legislation that punishes pregnant substance users and disproportionately affects poor minority women. For instance, in contrast to the current system characterized by surveillance and punishment, use results from urine screens to make recommendations for counseling or treatment.
- Promote gender-specific substance abuse treatment models that offer emotionally safe environments in which women can build support networks and deal with traumatic life experiences.^{20-21, 32} However, feminist treatment models that focus on women's unique needs and barriers should be sensitive to women's diverse social, cultural, and economic experiences. Treatment models that focus on empowerment in recovery should also be aware that these narratives can place responsibility for recovery solely on the individual, and thus place less emphasis on structural issues related to recovery.⁷
- Provide women in substance abuse treatment programs with access to child care services. These services would improve treatment engagement, treatment outcomes, and continuation of care after treatment.³³⁻³⁴
- Include other ancillary services in substance abuse treatment programs such as coordinating care with medical service providers to provide prenatal and pediatric care.³⁵ Provide substance abuse treatment program staff with training on medical stabilization for detoxification among pregnant women, as well as the potentially teratogenic effects of drug withdrawal.

Additional Resources

www.casacolumbia.org

www.drugabuse.gov/WHGD/WHGDHome.html

www.kap.samhsa.gov/products/manuals/taps/index.htm

www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.part.22441

www.oas.samhsa.gov/women.htm

www.seekingsafety.org/

www.stephaniecovington.com/

www.womensconsortium.org/

www.womenshealthresearch.org/

¹ Anderson, T. (2008). (Ed.). *Neither villain nor victim: Empowerment and agency among women substance abusers*. New Brunswick, NJ: Rutgers University Press.

² United States Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Office of Applied Studies. National Survey on Drug Use and Health, (2007) [Computer file]. ICPSR23782-v1. Ann Arbor, MI: Inter-university Consortium for Political and Social Research, 2008-12-01. DOI: 10.3886/ICPSR23782.

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