Chapter 7

Women Who Use Drugs and Mental Health

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Women who use drugs are often seen and represented primarily or solely for their substance use. Their general mental health is disregarded or their mental illness is not treated properly for diverse reasons. The aim of this chapter is to provide a consensual definition of mental health, mental illness and mental disorders, as well as an overview of related research findings on women who use drugs. Research studies and international organisations have revealed the gendered aspects of mental health by the concepts of gendered experiences, vulnerability, and disparity. Thus, we see a rather complex interrelation of topics in this chapter: women who use drugs, women and mental health, and women who use drugs and mental health. Mental illness is a complex phenomenon, and risky behaviour and substance use commonly occur simultaneously or subsequent to one another. A gendered vulnerability in biological, environmental, and behavioural risk factors has been registered in the development and escalation of mental illness. Studies have found that women who use drugs experience greater physical and mental health repercussions than men. Women who use drugs present higher rates of depression and anxiety, suicidal tendencies, isolation, and general psychological distress. This chapter addresses the definitions of mental health and illness and shows the most common mental illnesses associated with women who use drugs: depression, anxiety, trauma-related disorders, and eating disorders.

Defining 'Mental Health'

Mental health is a state of well-being that includes 'subjective well-being, perceived self-efficacy, autonomy, competence, intergenerational dependence, and self-actualization of one's intellectual and emotional potential, among others'

(World Health Organization (WHO), 2001a, p. 5). This definition implies that mental health is a complex concept that 'is not just the absence of mental disorder' (WHO, 2001a, p. 5). The interpretation of mental health varies according to the subjective assessment, the competing concepts and theories, and the cultural differences, and because '[f]rom a cross-cultural perspective, it is nearly impossible to define mental health comprehensively' (WHO, 2001a, p. 5). However, scholars agree that mental health and mental illness are aligned concepts. Mental health is a positive term but it is generally understood from a deficiency aspect. Mental illnesses can develop due to several reasons and particularly when the state of well-being is at risk and the performance of mental functions including productive activities, fulfilling relationships, and the ability to adapt and cope with adversity is unsuccessful. Mental disorders are defined and classified by their conditions, symptoms, and treatment in several distinct ways. This chapter will use the standard classification of the American Psychiatric Association (APA, 2013) published in the *Diagnostic and Statistical Manual of Mental Disorders*. The most common types of mental illness are anxiety disorders, mood disorders, and substance use disorders. Mental health problems are widespread globally, and 'mental, neurological and substance use disorders make up 10% of the global burden of disease and 30% of non-fatal disease burden' (WHO, 2019). Among the mental illnesses '[d]epression is one of the leading causes of disability, affecting 164 million people' (WHO, 2019). The aetiology of mental disorders is explained by several biological, psychological, and social theories. Numerous factors determine mental health both positively and negatively, including structural and socioeconomic determinants (race and ethnicity, gender, age, income level, education level, sexual orientation, and geographic location), interpersonal aspects, and environmental circumstances. There are various evidence-based effective treatments for mental health disorders, the most common being psychotherapy, medication, and self-help programmes.

Gendered Mental Health

Sex, a biological categorisation of male or female based on reproductive organs and chromosomes, and gender, one's sense of self as male or female in society (the socially constructed norms and expectations ascribed to individuals based on their sex) are regarded as critical determinants of mental health and mental illness (WHO, 2001b). According to the WHO (2001b, p. 2) gender plays a crucial role in explaining the risks of onset of mental health-related problems and treatment outcomes. Women have distinct neurobiological responses to stress. Several stress-associated disorders are more common in women, including depression, anxiety disorders, and post-traumatic stress disorder (PTSD). Furthermore, some reproductive hormones, such as estrogen and androgens, play a regulating role in mental illness. Globally, depression is twice as common in women. There is also a gender bias in the diagnosis of mental illnesses. Women are more likely to receive diagnoses of depression than alcohol-related diagnoses, and to receive prescriptions for tranquilisers and antidepressants (APA, 2018; WHO, 2001b). Some women experience mood symptoms

related to hormone changes during puberty, pregnancy, and perimenopause. Premenstrual symptoms are clinically significant factors in mental health issues for some women and can severely impact their lives. Risk factors include age, characteristics of the menstrual cycle, family history, and psychosocial stressors.

Structural determinants, such as gender, are meaningfully interconnected with several socioeconomic determinants, including income, employment and social position. Women experience greater levels of poverty, discrimination and socioeconomic disadvantage (APA, 2018; WHO, 2001b). This results in higher rates of depression and anxiety-related disorders including agoraphobia, panic disorders, somatoform disorders, and PTSD. Women's subordinate social status and traditional gender roles act as risk factors for mental illness. Gender-based violence such as childhood sexual abuse, intimate partner violence, and sexual trafficking of girls and women also play a significant role. Depression in adulthood was found to be more prevalent among those who have faced gender-based violence. Moreover, one in three women who have experienced rape develop PTSD (compared to one in twenty non-victims) (APA, 2018; WHO, 2001b). Also, women are more likely to report experiencing negative moods and to seek treatment for mental health issues. While there is debate around the explanations for women's mental health issues. Scholars agree that we need to consider the gender bias in problem recognition, help-seeking, diagnosis, and treatment, thus reassessing the nature of mental disorders among women.

Mental Illness and Substance Use: Comorbidity and Co-occurring Disorders

Mental illness is a complex concept, and risky behaviour and substance use commonly occur together. A national survey of care in the United States (Watkins, Burnam, Kung, & Paddock, 2001) found that almost half of the patients with addictive disorder had a co-occurring mental disorder; and with the orders reversed, those individuals with mental disorder had co-occurring addictive disorder between 15 per cent and 40 per cent (Watkins et al., 2001, p. 1063). Comorbidity and co-occurring disorders (COD) are described as the presence of one or more mental disorders related to drug use in conjunction with one or more mental disorders. Drug addiction is regarded as a mental illness. Although the correlation between drug addiction and mental illness is complicated and the causal connections are difficult to identify, the literature agrees on some plausible explanations. Common biological (genetic) and environmental (stress, trauma) risks can be contributing factors (Baigent, 2012; Santucci, 2012). Furthermore, overlapping neurobiological pathways are a possible explanation for COD. This phenomenon is called 'kindling' and it refers to the idea that repeated disruptions sensitise brain cells and 'that in vulnerable individuals, an underlying neurobiological tendency to sensitization may promote both drug dependence and mood disorders' (Quello, Brady, & Sonne, 2005, p. 15). Substance use and addiction, combined with other factors, may render the brain more vulnerable to mental illness (Baignet, 2012; Santucci, 2012). Self-medication has also been offered as an explanatory model (Khanitzan, 1997), stating that people with mental illness may use drugs or alcohol to alleviate symptoms (Santucci, 2012).

Gendered Comorbidity

Compared to men, women are more exposed to mental disorders like depression, anxiety, eating disorders, and PTSD (Center for Substance Abuse Treatment (CSAT), 2005, p. 229). Women are also more likely to have multiple comorbidity (three or more psychiatric diagnoses in addition to a substance use disorder), particularly involving mood and anxiety disorders (Zilberman, Tavares, Blume, & el-Guebaly, 2003). Furthermore, it was found that women are more likely to receive a primary comorbid diagnosis of depression, whereas men are more often diagnosed with a primary substance use disorder (Zilberman et al., 2003). Studies have found evidence that psychiatric comorbidity correlates with the sex-specific outcomes for treatment (APA, 2018; Zilberman et al., 2003). In a screening study of women veterans, Davis, Bush, Kivlahan, Dobie, and Bradley (2003) demonstrated that women with mental disorders, including depression, PTSD, and panic and eating disorders were twice as likely to have used drugs within the past year. Women who use drugs or alcohol experience greater physical health repercussions from their use than men, as well as higher rates of depression and anxiety, suicidal tendencies, isolation and general psychological distress (Canterbury, 2002, Cormier, Dell, & Poole, 2004; Mowbray, Oyserman, Saunders, & Rueda-Riedle, 1998). Some studies argue that the high level of mental distress might be caused by the condemnatory and stigmatising discourses surrounding women's substance use, based on the notion that women who use drugs and alcohol go against gendered societal expectations. According to the National Women's Council of Ireland (NWCI, n.d) up to 70 per cent of women who use drugs have experienced violence, and female drug users are more likely than men to have been victims of sexual or physical abuse (Astbury & Cabral, 2000; Canterbury, 2002; Cormier et al., 2004; Hedrich, 2000; Smith, McGee, & Shannon, 2001). Several authors argue that this indicates the importance of psychosocial factors, such as gender-specific socialisation and experiences, as predictors of substance use and mental health issues (Astbury & Cabral, 2000; Cormier et al., 2004; Smith et al., 2001). Differing coping mechanisms and symptom profiles are associated with the socialisation of girls and women. Women have multiple and sometimes conflicting roles as mothers, caretakers, and professionals. Girls are taught to behave in a manner commonly considered 'proper' by society and to control their anger, which can result in gendered coping mechanisms in adulthood. Symptom profiles also follow gendered patterns; ADHD is more commonly diagnosed among boys and eating disorders are more likely to develop in girls (APA, 2018). Among patients being treated for substance use, studies report that women have more difficulty with emotional problems whereas men have more difficulty with functional problems (work, money, and legal issues) (CSAT, 2005). Globally, women suffer greater exposure to social and economic disadvantage (WHO, 2001b) and they experience less control over their lives. The consequences of unwanted or unplanned pregnancies and marital or couple discord impact women in distinct social and economic ways. The tendency of misdiagnosis also has an impact on girls and women; their medical problems are often disregarded and treated as psychosomatic, obstructing access to appropriate treatment (APA, 2018). This has a major effect on mental health and COD.

As medical problems are not adequately treated, this results in worsening symptoms. Women and girls often exhibit self-accusation and shame, which have a negative impact on their overall well-being. Some groups of women are especially vulnerable, including single mothers, ethnic minorities, travellers, older women, and those who live in rural areas, experience homelessness, or who need special and integrated care. Integrated treatment addresses differential needs with the help of a multidisciplinary teams of experts. The diversity of groups and the issues they present are still not properly addressed in drug treatment facilities. The drug treatment measures, screening tests, and interventions in the United States were modelled on adult male heroin users and were often found ineffective for vulnerable women (APA, 2018). The role of biological factors as predictors has been studied but dismissed (Tuchman, 2010). Such factors include metabolism, the menstrual cycle, and higher rates of infertility, vaginal infections, liver problems, cancer, and transmission of HIV (Tuchman, 2010).

Mental Health Disorders Among Women Who Use Drugs

Generally, women who use drugs are poly-substance users; they use multiple substances including alcohol, medications, nicotine, legal and illegal drugs. The complex relationship between drugs, 'set' and 'setting' must be addressed (Zinberg, 1984). Women who use drugs exhibit a great diversity in set, meaning their physiology, health, state of being, culture, stage of change, history with substance use and their reasons for usage. Setting involves where women use drugs, with whom, the stress level, the quality of a support system, and their interpretations of their usage. Campbell and Ettore (2011) assert that 'gendered addiction' must be addressed and propose a new knowledge mode. The 'postclassical mode' recognises the different social norms and differential power positions that women and men face in addiction. The postclassical knowledge mode is post-disciplinary and goes beyond the multiple biomedical diagnoses and classifications which acknowledge 'race, class, gender and other modes of difference' (Campbell & Ettore, 2011, p. 6). Individual differences and a range of other factors, including genetic and personality traits, experience of trauma, and sociocultural differences, need to be considered when understanding comorbidity. Current studies (Becker, McClellan, & Reed, 2017) explain the term 'vulnerability' with the concept of escalation and understand vulnerability shown in individuals as 'those who show rapid escalation of drug taking' (Becker et al., 2017, p. 142). They argue that 15–20 per cent of the general population in the United States (Becker et al., 2017) can be regarded as 'vulnerable' and that within this group women tend to escalate drug use faster than men.

The nexus of gender, drug use, and mental health needs to be understood within this theoretical complexity. The mental disorders discussed here rarely present in such distinct categories when considered among women who use drugs.

Depression Among Women Who Use Drugs

According to the definition of the DSM-5 '[t]he common feature of all of these disorders is the presence of sad, empty, or irritable mood, accompanied by

somatic and cognitive changes that significantly affect the individual's capacity to function' (APA, 2013, p. 155). DSM-5 includes a separate diagnosis for 'Substance/Medication-Induced Depressive Disorder […] characterized by depressed mood or markedly diminished interest or pleasure in all, or almost all, activities' (APA, 2013, p. 175). Depression can be connected to different physical health problems, such as, chronic fatigue, or to the menstrual cycle, for instance through premenstrual dysphoric disorder, with varying severity (mild, moderate, moderate-severe, and severe), and can occur with peripartum onset. Depressive disorders can be classified under disruptive mood dysregulation disorder, major depression, persistent depressive disorder (dysthymia), and premenstrual dysphoric disorder.

Due to the interaction of biological and psychosocial risk factors, depression is widespread globally among women who use drugs. Depression is prevalent among socio-economically disadvantaged women (Tuchman, 2010). Some studies have found that increased depressive symptoms are connected to methamphetamine use (Tuchman, 2010). The comorbidity between major depressive episodes and substance use disorders is high (Agrawal, Gardner, Prescott, & Kendler, 2005; Zhou, Ko, Haight, & Tong 2019), although depression is often underdiagnosed among women who use drugs (Tuchman, 2010). Pregnant women who use drugs are more likely to exhibit depression, with mood episodes that can have their onset either during pregnancy or postpartum (APA, 2013, p. 152). Depression can play an initiating role in drug use but can also occur as a consequence or develop separately or concurrently.

Anxiety Disorders Among Women Who Use Drugs

Anxiety disorders include disorders that share 'features of excessive fear and anxiety and related behavioural disturbances' (APA, 2013, p. 189). Panic disorders can be divided into generalised anxiety disorder, separation anxiety disorder, selective mutism, specific phobias, social anxiety disorder, panic disorder, and substance/medication-induced anxiety disorder (APA, 2013). Panic attacks are extreme manifestations of an anxiety disorder.

Anxiety disorders and depression correlate and many studies focussing on women who use substances have found similar results. Those diagnosed with anxiety disorders have a high prevalence of substance use and substance use disorders (Agrawal et al., 2005; Zhou et al., 2019). Similarly to depression, the comorbidity is high but the correlation is unclear. Women who use opiates and cocaine also exhibit a higher prevalence of anxiety symptoms and anxiety disorders compared to their male counterparts (Tuchman, 2010).

PTSD and Trauma-related Diagnoses Among Women Who Use Drugs

Trauma- and stress-related disorders can involve '[e]xposure to actual or threatened death, serious injury, or sexual violence' (APA, 2013, p. 271) either by direct experience or by being exposed to aversive details of traumatic or stressful events. The severity of psychological distress and anxiety- and fear-based symptoms

vary. Trauma- and stress-related disorders include reactive attachment disorder, disinhibited social engagement disorder, post-traumatic stress disorder, and acute stress disorder (APA, 2013).

Compared to depression and anxiety disorders, the sequential relation of trauma- and stress-related disorders is clearer. Many women who use drugs report traumatic and stressful events such as sexual and physical assaults, childhood and adult abuse, and intimate partner violence (Agrawal et al., 2005; APA, 2018; Brady & Ashley, 2005; Tuchman, 2010). The prevalence of traumatic events in their lifetimes is higher than in the general population (CSAT, 2009). Typical symptoms of trauma- and stress-related disorders such as insomnia or intruding memories or flashbacks are treated with tranquillisers. Thus, self-medication with various substances is common. Some survivors may be aiming to increase their vigilance against further victimisation. Others may use alcohol to combat low self-esteem or increase their sociability (CSAT, 2009). Women who use substances are likely to have PTSD, and women with PTSD are five times more likely to have substance use problems (CSAT, 2009). Brady and Randall (1999) found that for many women PTSD is among the most common mental illnesses to precede substance use.

Eating Disorders Among Women Who Use Drugs

Eating disorders are 'characterized by a persistent disturbance of eating or eating-related behaviour that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning' (APA, 2013, p. 329). Feeding and eating disorders include pica, rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa, and binge-eating disorder (APA, 2013).

Studies (Harrop & Marlatt, 2010; Root et al., 2010) have reported a strong association between substance use disorders and eating disorders. Other studies suggest that women who are diagnosed with anorexia nervosa and bulimia nervosa are more likely to develop alcohol use disorders (Franko et al., 2005) and behavioural patterns of purging, but bingeing is not more strongly associated with substance use (CSAT, 2009). Overeating and bingeing are argued to be similar to substance use regarding reward sites in the brain and obesity may be a protective factor from developing a substance use disorder (CSAT, 2009).

Conclusion

This short overview of the topic of women who use drugs and mental health has revealed both gendered aspects of drug use and gendered mental health issues. Overall, recent research showed numerous gender differences in the epidemiology, socioeconomic determinants, neurobiological responses, progressions to dependence, COD, and comorbidity. With the help of the APA (2013) diagnostic classifications and definitions it is shown that the most common mental health problems for women who use drugs are depression, anxiety, PTSD and trauma-related diagnoses. and eating disorders. Poly-substance use is common and is associated

with adverse mental and physical health and social outcomes that result in challenges in both research and treatment. Despite the latest developments in gendered addiction studies, knowledge concerning the intersection of sex and gender in mental health and drug use remains less clear. Current studies on the topic emphasise that further research is needed to improve understanding and allow for more effective diagnosis and treatment.

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