PREVENTION RESEARCH BRIEF

ISSUE 01

WOMEN AND OPIOID USE

The Missing Link in Prevention, Treatment and Recovery

Network Coordinating Office

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PREPARED BY

Margaret Brommelsiek, Ph.D.
Director, Interprofessional Education Health Sciences Schools
Associate Research Professor, School of Medicine
and School of Nursing and Health Studies
Sr. Scientist for Research Writing, Prevention Technology Transfer Center (PTTC)
& Opioid Response Network (ORN)
University of Missouri-Kansas City

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Holly Hagle, Ph.D.
Principal Investigator (PI) and Co-Director, Prevention Technology Transfer Center Network Coordinating Office (PTTC NCO) and Senior Advisor for the Addiction Technology Transfer Center (ATTC) Network Coordinating Office (NCO), Associate Research Professor, University of Missouri, Kansas City

Laurie Krom, MA
Co-Director Prevention Technology Transfer Center Network Coordinating Office (PTTC NCO), Principal Investigator (PI) and Co-Director, Addiction Technology Transfer Center (ATTC) Network Coordinating Office (NCO), Program Director, University of Missouri, Kansas City

Rachel Witmer, BA
Sr. Project Manager University of Missouri, Kansas City, Prevention Technology Transfer Center Network Coordinating Office (PTTC NCO)

Rory McKeown, MPH
Consultant, Prevention Technology Transfer Center Network Coordinating Office (PTTC NCO) and Opioid Response Network (ORN)

Jack Wrisinger, MA
Visual Designer,
Collaborative to Advance Health Services

Katherine Atcheson
Sr. Project Manager University of Missouri, Kansas City, Prevention Technology Transfer Center Network Coordinating Office (PTTC NCO)

Van Wilson, MSW, MPH
Sr. Project Coordinator University of Missouri, Kansas City, Prevention Technology Transfer Center Network Coordinating Office (PTTC NCO)

Greg Grisolano, MA
Content Developer, Collaborative to Advance Health Services

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IN A REPORT ON WOMEN & DRUG USE, 19.5 million women 18 years and older (15.4%), reported using illicit drugs (illegal drugs) with 8.4 million (6.6%) reporting misuse of prescription drugs. While the reasons for using these substances are broad ranged—as a method of weight control, as a self-care strategy, or for pain management— these findings place women at increased risk for substance use and misuse (NIDA 2020).

Women's use and misuse of substances create unique challenges, especially in treatment and recovery from opioids (NIDA, 2018; Koons et al., 2018; Crane, 2015). Medical research on substance use by women (along with other health-related concerns) is largely lacking, especially research specific to women and their physiological differences and tolerance of substances to that of men (NIDA, 2020; Hyde, et al., 2019; McHugh et al., 2018; CDC, 2017; Clayton & Tannenbaum, 2016). In the case of opioids, this is significant. The exclusion of women in research addressing the opioid epidemic has created a crucial knowledge gap for ensuring successful prevention, treatment, and recovery for women who use, misuse, or have an Opioid Use Disorder (OUD).

Women, Pain Management, and the Opioid Connection

Pain and the opioids prescribed in the treatment of pain have primarily been diagnostically determined from a male-dominated perspective, despite differences in the reporting of pain between male and female patients (Koons et al., 2018). Females described pain as being longer in duration, affecting multiple areas of their body, and reported a higher severity level of pain as compared to their male counterparts (Pieretti et al., 2016). The provider's gender and interpretation of a female patient's description of pain can greatly impact the provider's treatment decisions (Pieretti et al., 2016). In a study examining pain management between male and female patients who underwent coronary artery bypass surgery, the male patients were more likely to receive opioids for managing their pain, whereas the females were provided sedatives because their providers perceived them as being anxious, rather than experiencing actual pain (Calderone, 1990). Such disparity in the treatment of pain in women is concerning on two levels: women may be denied appropriate pain medication in treating their pain and/or they may become victims of too much pain medication if decisions are based primarily on a provider's perception or if treatment of their pain is largely informed by research conducted on males only. Thus, gender makes a difference in how an individual is treated, responds to, or may become addicted to pain medication, especially in the case of opioids.

Domestic Violence and Opioid Use

While there are multiple factors influencing why women begin using opioids, domestic violence—particularly intimate partner violence (IPV)—is a leading cause, with women seeking treatment for OUD reporting greater rates of IPV (Pallatino et al., 2021; Engstrom et al., 2012; El Bassel et al., 2007; Burke et al., 2005). However, research concerning the link between IPV and OUD is limited (Stone & Rothman, 2019; Rothman et al., 2018). Victims of IPV often assign use of opioids as a way of coping, while others use opioids as a result of coercion by a partner (Anderson & Boldt, 2022; Rivera et al., 2015). These two epidemics (opioid use and intimate partner violence) create a repetitive cycle that place these women at greater risk of developing an opioid dependency (Anderson, 2002; Lipsky et al., 2005; Smith et al., 2012). Both have now evolved into a larger social response, not only as a criminal justice issue but one of public health (Simonelli et al., 2014).

Women, Stigma, and Opioids

Widespread health events assigned as an underlying social cause, such as the opioid epidemic, often cause the redistribution of value to certain individuals that can categorically alter their social status from collective equals to having a lesser value (Hofstadter, 2007). Such clouding of perception particularly impacts individuals seeking care during health events

categorized as epidemics as well as events that are viewed as having an underlying social cause. According to Lakhoff and Johnson, ninety-five percent of human reasoning is shaped by the unconscious mind by what they describe as the 'hidden hand', in the way we perceive and where blame, failure, and deception reside (1999). This suggests that the unconscious mind has significant power to influence conscious actions that may ultimately create barriers. Society as a culture also has a conscious and unconscious understanding that shapes its beliefs, ideas, and attitudes. This informs its function as a unified body; a collective consciousness (Smith, 2014).

Conceived as a way to comprehend and explain the behaviors and attitudes of society as a whole, collective consciousness is a kind of normalization of individuals' actions based on wide-ranging standardization and categorization (Durkheim, 1982). Unfortunately, this approach can produce isolation and alienation of those who either do not conform or fall outside of preconceived norms established by the collective whole. For those individuals categorized and thus identified as members of a threatening subset (such as those who use substances) not only is their status diminished but their value is reduced because of alienation and stigmatization. In terms of well-being, the link between social stratification via stigmatization can greatly impact an individual's ability to access necessary resources, including equitable treatment and recovery from substance use. When considered in this context, these individuals have been socially branded. Women in particular, who use, misuse, or have an OUD are victims of both stigma and social alienation because of their use of substances . Goffman assigned two distinct processes for ways in which individuals manage stigma: discredited when they are cognizant of their stigma, and discreditable where they can hide their perceived stigma through a process of impressions management wherein an individual controls or influences the impressions others may have about them (Goffman, 2021; Lee & Boeri, 2017). Those choosing to hide their stigma, according to Pachankis, spend copious amounts of energy to ensure not only that their stigma is not apparent, but a need to draw attention to their more positive aspects as an act of concealment (Goffman, 2009). Despite efforts to own or conceal stigma, stigma can wreak havoc on both mental and physical well-being, leading to additional isolation and perceptions of alienation (Chaudoir et al., 2013; Quinn & Chaudoir, 2009; Pachankis, 2007).

Women are often assigned stigma through an unfair double standard that society, and even healthcare, has placed on them. The use of substances by women, especially the use of opioids, place women squarely in the camp of those most often stigmatized because it goes against how society views the female identity, and therefore gives them the persona of a 'bad woman' (Lee & Boeri, 2017; Boeri, 2013; Campbell, 2000; Goffman, 2021). When a woman is either a parent or pregnant when using opioids, the harsh labeling and stigmatization assigned to this individual go so far as to characterize them as being guilty of moral failure or as having a spoiled societal identity (Stengel, 2014; Howard, 2015; Stone, 2015). Such malicious judgment has kept some women, especially those who are pregnant or a parent, from seeking treatment and recovery services by creating additional barriers to negotiate in the process of getting well. (Crawford et al., 2022; Frazer et al., 2019). Even after recovery, many women who are parents or were pregnant at the time of their opioid use must still contend with stigmatization and negative labeling post-recovery (Roberts, 1991).

DISCUSSION

Women have been significantly impacted by the opioid epidemic, and as such, are at increased risk of having an OUD because their bodies respond differently than that of men due to hormonal factors. (Dunn et al., 2020). The treatment of women with OUD is more complex because of a need to address both physical and mental well-being that includes not only physical and emotional pain but may also include personal trauma experienced from years of abuse. Additionally, women seeking treatment have a greater risk of negative outcomes than men because they may have greater difficulty with withdrawal (Huhn & Dunn, 2020; Williams & Williams, 2020; Short et al., 2019).

Accessing treatment is also different and difficult for women. For example, women may have had a negative experience of healthcare that has led to fears about confidentiality, or harbor safety concerns due to a prior history of abuse (Commonwealth, 2020; Pagan, 2018; Kiesel, 2017; Schwei et al., 2017). For some women, this has meant choosing to defer treatment and avoid seeking care for their OUD (Andres et al., 2011; Covington, 2002). Changing the current culture in prevention of OUD in women will only occur by recognizing that gender matters. This

will require the letting go of long-held misconceptions concerning women and their opioid use by employing a strategic approach to both reduce existing barriers to treatment and care, as well as increase confidence in those seeking help. Without change, women who use opioids may potentially put off seeking treatment or hesitate due to past experience with shaming and/or stigmatization, which prolong recovery. Meeting the unique challenges and needs of women struggling with OUD calls for a collaborative approach among healthcare, service providers, and community agencies in making recovery more equitable and accessible.

CONCLUSION

Women who use, misuse, or have an OUD are continuing to increase in number and comprise a growing sector of the larger opioid epidemic. While multiple factors influence the use of opioids among women, emotional and physical pain (particularly pain induced by trauma) requires a more gendered approach of prevention, treatment, and recovery. A first step is the reduction of barriers preventing women with OUD from seeking care, such as stigmatization and harsh labeling or judgment that comes from the very individuals within healthcare, community, and service agencies that are designed to help. Stigmatization of women remains a leading cause of why many women are deterred from seeking assistance for their OUD and is even more prevalent among women who are pregnant or a parent, thus impeding recovery. Understanding the unique physiological and emotional challenges of women with OUD is significant for reducing this sector of the opioid epidemic, and relies on coordinated gendered specific prevention strategies alongside the reduction of stigmatization and treatment barriers toward the road to equitable recovery.

KEY POINTS

- Women with OUD face unique challenges
- The connection between OUD and IPV is significant
- Stigmatization of women with OUD delays recovery
- A gendered approach to prevention and treatment is necessary
- A collaborative multi-agency approach for serving women with OUD is crucial

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