Addressing Women's Sexual Health Disparities in Substance Use Disorder Treatment

By Raven Badger, PhD

The demographics of substance use have changed dramatically over the past 20 years. Many health issues directly linked to substance use disorder disparities include a sexual component, (e.g. STIs/HIV, sexual behaviors, reproductive health, sexual dysfunction, sexual orientation, sexual assault), yet few treatment approaches currently exist to address women's sexual health in substance use disorder treatment. The Institutes of Medicine recommends that the National Institutes of Health implement research agendas designed to advance scientific knowledge and understanding of women's health, including inequities in health care and research to develop and test the effectiveness of interventions that address health inequities and negative health outcomes experienced by women, minorities and by LGBT people.

Connections Between Sexuality and Women's Substance Use Disorder

The link between sexuality and women's substance use disorders are well supported by research. Substance use, in and of itself, brings with it sexual health disparity risks for women (e.g., increased risk of breast cancer, and fertility-related disparities including higher infant mortality and pregnancy risks for women of child-bearing age). Women who have had multiple abortions remained at an increased risk of having a substance use disorder compared to women who had no abortions (Steinberg & Finer, 2010). Pregnant women with prior history of infertility problems are at increased risk for alcohol abuse and are more likely to suffer from other psychiatric disorders than women without such history (Karjane, Stovall, Berger, & Svitkis, 2011). This is based in part due to their fears of miscarriage from past infertility issues. Women with infertility diagnoses tend to present higher levels of depressive and anxiety symptoms in comparison with fertile controls and adoption candidates (Galhardo, Pinto-Gouveia, Cunh, & Matos, 2012). Infertility diagnoses and substance use disorder are linked to negative affective reactions, such as the grief and loss associated with the inability to produce children in a culture that values women for their reproductive functioning.

Increases in posttraumatic alcohol usage predicts increases in posttraumatic sexual activity, suggesting that use of alcohol as a coping strategy from sexual assault may result in an increased likelihood of engaging in risky sexual behavior (Deliramich & Gray, 2008). Women with histories of sexual abuse during childhood/adolescence experience high rates of sexual dysfunction, such as desire disorders and inability to experience sexual pleasure or orgasms. Negative body image and resulting disordered eating, intimacy issues, lack of sexual desire and pleasure and sensuality issues have been correlated to relapse and substance use disorder in women (James, 2012).

For some individuals who identify as lesbian, gay, or bi-sexual, social stigma associated with sexual orientation may induce psychosocial stress, leading to high risk behaviors and poorer health outcomes (Coker, Austin, & Schuster, 2009). Resulting social stigma can lead to avoidant coping strategies such as substance use disorder, disassociation, and emotional suppression (Staples, Rellini, & Roberts, 2004). One study found that minority stressors and available social-psychological resources had a significant impact on the mental health and substance use among sexual minority women (Lehavot & Simoni, 2001). These researchers recommended health care professionals assess for minority stress and coping resources and refer patients for evidence-based psychosocial treatments. However, the lack of tailored evidence-based psychosocial treatments persists.

The Meaning of Sexuality for Women in Treatment

Sexual shame has been linked to substance use disorders and subsequent relapse in women (James, 2011 & 2012). Lowering sexual shame has also been linked to increased client retention and improved treatment outcomes (Braun-Harvey, 2010). Research related to the identification of sexual shame and low sexual self-esteem (SSE) in women noted numerous themes, including: being raped, being blamed for rape or molestation, not being believed about sexual abuse, negative reactions from family and friends, religious messages that conflicted with sexuality, sexual behaviors (prostitution, multiple sex partners, etc.), not feeling comfortable about sex, feeling pleasure from sex, body loathing, infertility, getting HIV and STIs, inability to orgasm, same sex orientation, and not feeling "good enough" sexually.

In a series of focus groups conducted as part of a larger study in 2010 (Badger), when asked what they would like to see included in treatment related to sexuality, women reported a desire to discuss the afore-mentioned

themes as part of their treatment process. Women also wanted validation of their feelings around abuse; some of the women had brought up sexual issues in treatment and were "shut down" by their counselors and told "we don't talk about that here" or were met with awkward silence and shifted to another topic. Several women reported wanting permission to talk about sex and sexual abuse, stating that not being allowed to discuss their intimate sexual secrets increased the shame they had felt about their past behaviors and experiences. The outcome was essentially one of re-victimization and reportedly contributed to continued sexual shame and relapse. All of the surveyed women reported direct links to their substance use and relapse related to their sexual attitudes, feelings and behaviors.

Based on this research, we have developed women's sexual health intervention that includes the following emergent themes:

REPRODUCTIVE ISSUES: This theme centers on a person's capacity to reproduce and the behaviors and attitudes regarding reproduction issues. Critical components of substance use disorder treatment include providing accurate information about reproduction, feelings and attitudes (about condoms, abortion, etc.), sexual intercourse (oral, anal, and vaginal), and sexual reproduction (processes of conception, pregnancy, delivery, and infertility). While many women reported having some information in this area, experiences that had negative consequences, such as abortion, infertility, or disease, not only resulted in substance use and relapse, but created an expressed need to process feelings and attitudes related to those issues.

SENSUALITY: Sensuality has to do with awareness and enjoyment of one's own body and the bodies of others. Sensuality enables people to feel pleasure in a reciprocal manner and feel good about how their bodies' look and feel and what they can do. Sensuality affects behavior in several ways, including body image, human sexual response, satisfying the need to be touched, and experiencing pleasure and fantasy. Women reported multiple links to sensuality and substance use in all of these areas; they reportedly used substances to feel better about how they looked and engaged in risky sexual behaviors in order to feel loved or be touched and to reduce feelings of sexual shame when they felt undesirable or had experienced sexual dysfunction.

INTIMACY: Intimacy is the ability to be emotionally close to another human being and to accept closeness in return. Several aspects of intimacy include sharing, caring, loving and liking, emotional risk-taking, and vulnerability. Women's intimacy was reportedly impacted by substance use. Some reported that they were unable to be close to a sexual partner due to past abuse, or were in fear of being vulnerable in a relationship. False intimacy was common among women when they shared sex for drugs, financial support or a place to stay. Being able to create a healthy sense of self can help enable women to develop intimate relationships with sexual partners. Rather than facilitate a sense of how to form healthy relationships in recovery, many treatment programs espouse the norm of relationship avoidance.

SEXUAL AND GENDERY IDENTITY: Sexual identity includes an understanding of sexual attraction, sexual behaviors based on that attraction, and the sense of being male or female. Sexual identity consists of several components that, together, affect self-perception. Gender identity, gender role, gender bias, and sexual orientation comprise this theme. Internalized homophobia, transgender issues, sexism, heterosexism, and associated stigma were greatly associated with women's subsequent substance use and potential relapse. Many women reported feeling re-traumatized or unsafe to "come out" in treatment due to provider bias around sexual and gender identity.

COERCIVE SEXUAL EXPERIENCES: Sexual experiences considered coercive range from seduction, withholding sex and sexual harassment, to sexual abuse, incest and rape. A large majority of women expressed direct links to substance use disorder in this realm by being sexually exploited and abused. Creating an environment where it is safe to process the effects of sexual coercive experiences and begin the healing process is critical to prevent relapse for affected women.

SEXUAL SHAME: Women's sexual shame was linked to internalized negative reactions and messages from family and friends, culture, religious and spiritual figures, and societal institutions regarding their sexuality. Reinforcing negative sexual beliefs can be counterproductive to the recovery process if it results in shame-based thinking. The internalization of what is deemed healthy (through societal norms, religion, politics, and education) becomes the mechanism that causes the distress in individuals as they develop and attempt to form relationships based on limited options for perceived "normal" sexual functioning.

Conclusion

A positive women's sexual health intervention presents a scientific framework from which to address the links between women's sexuality and substance use disorder. When substance use disorder treatment perpetuates client shame and low sexual self-esteem, it inadvertently leads to ineffective treatment outcomes. A holistic approach to recovery incorporates a myriad of techniques that include positive sexual health messages. Recovery is about change, and in order to facilitate healthy change, clinicians must have requisite knowledge and consider variables related to the problematic use of substances, including the sexual self.

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