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Psychiatric co-morbidity among women with substance use disorders

Epidemiological and clinical studies have described a high co-occurrence of substance use disorders (SUD) and other psychiatric disorders, known as “dual diagnosis” (Torrens *et al.*, n.d.; Kingston *et al.*, 2017). These patients with a dual diagnosis are reported to have more emergency admissions, higher prevalence of suicide, increased rates of medical co-morbidity, more risk of relapse in drug use and psychiatric disorder, higher unemployment and homelessness rates and greater incident of violent or criminal behaviour (Greenberg and Rosenheck, 2014; Krausz *et al.*, 2013; Martín-Santos *et al.*, 2006). This dual diagnosis group of patients show poorer treatment outcomes, more clinical and social severity compared with patients with only one disorder, resulting in a high cost to the society (Krausz *et al.*, 2013).

Although SUD is more frequent among males than females, the likelihood of having a comorbid psychiatric disorder is twice as high among women (Torrens *et al.*, 2011). Among the drug-dependent women, dual diagnosis prevalence ranges between 15 and 100 per cent (Frem *et al.*, 2017). Mood, anxiety (including post traumatic stress disorder), eating and borderline personality disorders are the most prevalent disorders, and also more frequent in females in comparison to men (Torrens *et al.*, n.d.; Frem *et al.*, 2017).

Research taking a gendered perspective among patients with coexisting SUD and psychiatric disorders has been growing during the last two decades, but little is known about the mechanism that mediates gender differences (Torrens *et al.*, 2011). A number of potential risk factors may explain this higher psychiatric comorbidity: women with SUD have shown higher genetic vulnerability, more psychiatric disorders in their family history or higher environmental stress that may result in an increased experience of family disruption (Kuehner, 2017). Among these factors, women who are drug dependent are frequently involved in intimate relationships with drug using partners and may support their habits through sex trading and prostitution more frequently than men (Gilchrist *et al.*, 2015). In addition, intimate partner violence (IPV) is highly prevalent among women seeking treatment for a SUD (Gilchrist *et al.*, 2015; Kuehner, 2017; Weaver *et al.*, 2015). The rates of IPV are higher among women who use drugs (25-57 per cent) compared to women who do not (8-16 per cent) (El-Bassel *et al.*, 2011). A meta-analysis of longitudinal studies found a bidirectional relationship between SUD, alcohol in particular, and IPV victimization (Devries *et al.*, 2014). When a SUD is co-occurring with depression or a PTSD, women are more vulnerable to experiencing IPV, less able to detect signs that lead to episodes of violence and less likely to access resources that may improve safety (Farré *et al.*, 2017; Iverson *et al.*, 2013; Weaver *et al.*, 2015). IPV experiences are associated with sexual and injecting risk behaviours such as, less use of condoms, sharing injecting equipment and having multiple sexual partners, which are associated with an increased risk of blood-borne viruses (e.g. HIV and Hepatitis C) and sexually acquired infections. Furthermore, women who use drugs and are suffering IPV are more likely to continue using drugs and have more relapse as a result (Campbell *et al.*, 2008; Weaver *et al.*, 2015). A high rate of co-morbid psychiatric disorders and IPV has also been described among women who inject drugs (Tirado-Munoz *et al.*, 2017).

In comparison to opioid-dependent men, women with opioid use disorder are more likely to be younger, victims of emotional, physical or sexual abuse, and tend to have high rates of psychiatric co-morbidity and multiple SUDs together with complicated social and family dimensions (Green *et al.*, 2009), all of which can impede recovery.

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Some additional gender-specific determinants that can influence the expression of dual disorders should be taken into account, like gender inequalities in social circumstances, a greater likelihood of living in poverty among women, the need to combine family responsibilities with work, education, stigma attached to substance use among women, higher risk of victimisation and social expectations for women (Stewart, 2007).

Furthermore, the prevalence of psychiatric co-morbidity among pregnant women who use substances is also significant, varying from 57 to 91 per cent (Coleman-Cowger, 2012; Strengell *et al.*, 2015). Postpartum mood disorders affect approximately 10-20 per cent of women and this prevalence increases among women with lifetime substance use (Prevatt *et al.*, 2017).

In short, women with SUD present more psychiatric co-morbidity than men with SUD and women without SUD; the most frequent psychiatric disorders being depression, anxiety and PTSD. They also have a greater risk of suffering IPV and report more sexual and injecting risk behaviours associated with HIV and HCV infection. These particularities have an impact on both disorders in terms of response to treatment and quality of life; therefore, psychiatric comorbidity among women seeking treatment for their SUD, should be specifically addressed. Policy makers must guarantee the access and appropriate treatment to women with SUD and comorbid psychiatric disorders.

Since the 1990s, a proliferation of gender-sensitive programs have been developed that focus on gender-specific needs, such as caretaking roles, IPV and trauma, risk behaviours, reasons for relapse and co-occurring psychiatric disorders. Additional research is needed to develop and test effective substance abuse treatment interventions for subgroups of women taking into account the diversity of socioeconomic circumstances, cultural background, substances of abuse, family status, risk factors and clinical and psychiatric comorbidities (Greenfield and Grella, 2009). Finally, future studies should explore the underlying genetic, psychosocial and environmental factors that are influencing the development of dual disorder, and possibly underlie gender specificity.

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