Substance Use Disorders & Violence Against Women

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Recently the World Health Organization (WHO) revealed in its report, "Depression and other Common Mental Disorders," that Chile is among the countries with the most cases of mood disorders in the region. More than one million Chileans suffer from anxiety and 850 000 from depression. The prevalence of depressive symptoms in women is almost triple and in general, mental health disorders tend to affect this sector of the population more than any other. (Ministry of Health, MINSAL, 2010; Vicente, B. et al, 2002).

Within mental health disorders, the problem of drug consumption has become more visible in recent years in the female population. It is a complex and multi-causal phenomenon, and tends to be interlaced with other problems of a psychosocial nature. Of the 54 women treated in 2016 at the Dianova Centre for Outpatient Treatment in Viña del Mar, 83% had a history of intrafamily violence and/or sexual abuse[1] (Treatment Information Management System, SISTRAT, 2016).

The aim of this article is to highlight the close relationship between substance use disorders (SUD) and violence against women (VAW), as well as the ways in which both phenomena are interlinked, from a gender perspective. Presenting from a gender perspective allows us to report on the effects of gender socialization which involves identifying the specific problems that afflict women who attend our centres and the effects of having been socialized as such, including the impact on their consumption path (motivations, relapse processes, consumption patterns, etc.). Gender is a symbolic construction - thereby debatable and mutable - based on difference between the sexes, which affects the subjective constitution, creates identity and dictates behaviour patterns. Historically we have witnessed a structural inequality between men and women as a result of an undervaluing of the female gender (Martínez, 2008).

In writing this article, as an ethical and political choice, we have chosen the term "Violence Against Women" (VAW). Unlike others[2], this rescues the concept of "intersectionality" (Crenshaw 1995 in

[1] It must be considered that this data is collected at the beginning of treatment and that therefore the actual figure tends to be higher since, through shame, many women do not reveal such information in the first interviews, or simply do not admit to being in a violent relationship.

[2] Intrafamily violence: places focus on that which is intrafamily addressing the issue as a private matter and making women, who are the main victims, invisible; Domestic violence: confines the violence to the private sphere, stripping it of its socio-political roots, in addition disregarding the structural violence of the State; Gender violence: which alludes to gender, is broader and non-specific to women.

Tornay and Oller, 2016) that takes into account that oppression originates from a variety of structures, understanding gender as a dynamic category that converges with other inequalities and realizing that the various ways in which the differences are being articulated, social stratification, and discrimination/oppression are interconnected (e.g. ethnicity, class, gender, etc.) (Kauppert and Kerner, 2016).

Let us, therefore, speak from a feminist perspective which views the problem as a sociocultural one, rooted in patriarchal violence including, moreover, structural violence perpetrated by the State itself. It is not, then, an individual nor a psychological problem which, from different perspectives, we are trying to pathologize. The feminist standpoint argues that violent men are not mentally ill, but rather, "healthy children of the patriarchy".

According to the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (Article 1) VAW is understood as "any act or conduct, based on gender, which causes death or physical, sexual or psychological harm or suffering to women, whether in the public or the private sphere". Global statistics indicate that 35% of women have experienced physical or sexual violence at the hand of their partner and that 38% of murdered women are killed by their partner (WHO, 2016). For its part, the Chilean Network Against Domestic and Sexual Violence Against Women, recorded 52 femicides in 2016.

Beyond the statistics, this is a severe problem that has implications not only in terms of the mortality of women, but also presents a number of unseen consequences at different levels, such as the mental health of this population and specifically, the central theme of this article: substance use disorders.

The prevalence of consumption last year in Chile for various drugs include: cocaine 1.4%, cocaine base 0.5%, marijuana 11.3%, tobacco 22.7% and alcohol 48.9% (National Service for the prevention and rehabilitation of Drug and Alcohol Use, SENDA, 2015). Among the female population there is higher consumption of tranquillizers, while men are more inclined towards stimulants (United Nations Office on Drugs and Crime, United Nations, UNODC, 2005, 2016).

The relationship between substance use disorder (SUD) and violence occurs at different levels: a) Drug consumption can trigger violent acts, related to the effects of the drugs. b) Commission of crimes to obtain funds to buy drugs. c) Systemic violence linked to substance trafficking. d) The traumatic effects of violence (such as political violence) increase the risk of drug use. (UNODC, 2016).

Typically, women who use drugs are exposed to more violence than men. The social stigma - symbolic violence - that befalls them, through challenging traditional roles associated with gender stereotypes (good mother-wife), is greater. In the legal field, for example, in the case of sexual violence, abusers who use drugs are let off, the drugs being a mitigating factor for their actions, whilst for women they are an aggravating circumstance. This demonstrates the classic association that links alcohol or other drugs to virility in men but which associates them with promiscuity in women (increasing the risk of sexual assault). Women also face institutional violence by family courts and child services, which are highly abusive to women who are mothers and that consume drugs; a fact which worsens their condition and reduces the potential for recovery.

The underlying factor of all this is a structural form of violence anchored in the inherent disadvantage suffered for the mere fact of being women (fewer educational and employment opportunities, and economic dependence among others), increasing the likelihood of a fall into a spiral of marginalization, poverty, micro-trafficking and/or prostitution (up to 60% of women drug users turn to prostitution to fund their addiction. Alternatively, the reverse is also true: women involved in the sex trade are induced or forced into drug consumption by their pimps as a means of submission) (García, 2005. Sirvent, 2005. Plaza, 2005. Del Pozo, 2005. Llopis, 2005).

A woman who is a victim of violence is 15 times more likely to suffer a Substance Use Disorder (SUD). As for women who are treated for SUD, they are 3 times more likely to be victims of violence at the hands of their partner than the general population. In turn, between 50 and 80% have been victims of sexual abuse in childhood (Llopis, 2005).

Violence can be experienced as a result of consumption, as shown by the model of dis-inhibition, where drugs would trigger a loss of impulse control, the most common being stimulants (which increase paranoia) and alcohol (which reduces impulse control). Alternatively, drug use may be a consequence of violence, common in the case of battered women who use substances as pharmaceutical treatment or for self-medication (Khantzian, 1985, in Tenorio and Marcos, 2000), to reduce the anxiety and emotional unrest caused by their situation.

Many of the women subjected begin consumption through their partners as a way to keep the relationship or because they are forced, and if they begin treatment this is usually boycotted by the abusive partner. When immersed in a relational dependency[3], women tend to justify the abuse by behaviour related to consumption or relapses. On the other hand, we see independent women who, as a result of the hyper-competitive workplace added to a masculinization in performing their role, look to substance use as a way to tolerate the stress of having to juggle multiple roles in a society that does not cater for this. In both cases the situation is complex because women are prone to become dependent more rapidly and with worse effects than men, due to physiological and metabolic differences (UNODC, 2005 and 2016).

While triggers to drug consumption in women can be varied (to tackle a problem, to relax, to fight boredom, frustration, unsatisfying sexual relationships, to lose weight, multi-problem families, economic hardship, etc.), violence is usually a common denominator for consumers. There is a sociocultural and contextual factor that normalises violence as a way of relating to each other as existing transgenerational patterns become an internalisation of domination.

Stories of violence often begin in childhood with child sexual abuse (CSA), generating traumas that subsequently manifest in Post-Traumatic Stress Disorder (PTSD) and other mental health disorders. From there, the SUD become a coping mechanism against the stressor. Childhood trauma forges a self-perception of the sufferers being carriers of a "stigma", which facilitates identification with marginalized groups and in turn, access to substances. In adult life, the experiences of violence to which the sufferer is accustomed become "normal" as a continuation of the CSA, diluting the barriers against prostitution (Llopis, 2005).

[3] A set of addictive behaviours based in interpersonal relationships. It is caused by an asymmetry of roles, either by voluntary submission of the dependent member, or as a result of overbearing dominance. It generates a dissolution of the dependent person's personality,an habitual passivity and lack of autonomy. It is a typical phenomenon of women who use drugs, applying to 70% of cases (García, 2005. Plaza, 2005. Del Pozo, 2005. Llopis, 2005).

The features the mental health disorder takes on, whether linked to use of substances or another factor, can be associated with stress coping mechanisms generated by the demands of gender stereotyping (Romo, 2003). In this way, the tension generated between the roles traditionally associated with women (motherhood, housewife, caretaker, etc.) and the emerging roles they are playing in society (worker, politician, active agent in public space, etc.), leads to stress and various types of symptomatology as well as coping mechanisms (use of substances or otherwise).

It becomes necessary to make visible the social determinants and gender stereotypes associated with mental health. For example, in response to these same emotional complaints (tiredness or fatigue) women tend to be prescribed psychotropic drugs, thus pathologizing the everyday stress of a "triple shift" (work, housework and care) that would exhaust anyone. This has led to an over diagnosis of depression in women and a disturbing tendency to abuse psychotropic drugs (Pla et al., 2013).

Dio Bleichmar (1991) suggests that psycho-social factors occurring in depression (dependence, passivity, lack of firmness or assertiveness, great need for emotional support, worthlessness and helplessness) fit the stereotype of femininity: "... what predisposes a woman to depression is her own role. It is femininity itself, as conceived in our culture, that is the greatest risk factor for depression" (p.286). From that it is important to approach to mental health from a gender perspective that considers how cultural patterns that govern the behaviour of women and men affect the social unease that they generate and the related disorders that can develop over time.

Having reviewed the forms of relationship between VAW and SUD, some challenges and considerations for intervention now arise. In light of the structural inequality that affects women, it is necessary to invest more effort in their social integration; especially those suffering from SUD whose barriers are greater due to stigma, who show a lower capacity for self-reliance (through a history of dependence), with lower education levels and access to low-paying jobs.

Strategies are required to attend, holistically, to both problems. The shelters, provided by the National Women's and Gender Equality Service, exclude drug users, whether they have suffered abuse or not. Nor do addiction treatment centres have specific programs for abused female drug users.

Through therapeutic work, the aim is to create new patterns of interpersonal relationship whereby cultural submission is no longer a part of gender stereotypes. Accordingly, in the same way that relationships with others have been a concern (under the mandate of gender stereotyping linking femininity to caring for others), self care must also be encouraged. The loneliness and exclusion experienced by women drug users impels them to expand their support networks, generating self-help groups founded in sisterhood[4].

Women, just like any person, are at risk of becoming victims of violent actions of various kinds. However, their vulnerability is increased by the mere status of being a woman. Socially and

[4] Sisterhood calls for an alliance among women, fellowship, where there is no hierarchy, but each recognizes the authority of the other and of the group. It involves strengthening through reciprocity, opposing competitive and discriminatory relationships (Lagarde, 2012).

historically, based on the patriarchal culture, society has allowed - and even legitimized - women being attacked in the basic areas of personal development: "... abuse in the family, rape in the social environment and sexual harassment in the workplace" (Altell and Plaza, 2005, p.105).

Although progress has been shown in equal opportunities for gender, the gap is still wide and has acquired more subtle lines. From this standpoint it is necessary to stress and denature gender stereotypes and prejudices that circulate among both the users themselves and mental health professionals alike. Gender and psychosocial factors give way to various forms of suffering and sickness, as well as different methods of approach to health services, which cannot be ignored; otherwise we would be perpetuating a history of inequality and violence.

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