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# Special Needs in Substance Use Treatment for Women Who Use Drugs: Social and Mental Health Factors

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**Abstract:** Women who receive substance use treatment have a particular classification of sensitivity to European drugs and drug use (according to the EMCDDA). The average level of women's treatment is lower than men's across Europe, while women's abandonment is higher than men's. The purpose of this study was to examine the factors associated with problems for women who use drugs, analyzing several psychological and social factors (gender, substance use, mental health, source of economic support, legal status, and abuse). Methodology: This was a quantitative study. Data on 2179 people receiving rehabilitation treatment were obtained from the EuropASI survey. The dependent variables in this study were (1) a patient's known history of addiction and mental illness; (2) primary drug use; (3) drug use in their lifetime and the past month; (4) mood in their lifetime and the past month, physical condition, and sexual abuse history; (5) mental illness in their lifetime and the past month (including suicide attempts); (6) legal status in their lifetime and the past month; (7) and source of income in the past month and (8) and the number of patients. The factor of gender was taken as a dichotomous variable (male–female). The confidence interval used was 95%. Results: In summary, we found that women had consumed more alcohol, used more drugs, and suffered more from depression, anxiety, and suicidal ideation than men, both during their lifetimes and in the past month. In addition, women were more likely than men to be stigmatized for prostitution because their financial support came mainly from colleagues, friends, and family, as well as from prostitution. Finally, women had experienced more violence (emotional, physical, and sexual) during their lifetimes and in the last month than men. Conclusion: There appears to be a need to develop a comprehensive treatment network for addictive behaviors from a multifactorial perspective, including harm reduction, psychosocial support, and recovery programs; furthermore, targeting specific groups with special needs, such as women, especially those with mental health problems, women with alcoholism, and abused women, it also seems important to develop adaptive recovery programs within addictive behavior treatment networks.

**Keywords:** gender perspectives; social and health problems; psychosocial factors; women in addiction treatment



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## 1. Introduction

There is the notion that addressing the risks and issues associated with problematic drug use entails looking at the population as a whole and predominantly seeing men as the neutral component, this is known as a lack of gender approach when designing and implementing drug treatment services. Certain models hold that drug use in women lacks distinctive characteristics and give the same interpretations and intervention strategies

for both men and women [1,2]. In this sense, harm reduction programs versus recovery-based programs is the fundamental division within socio-sanitary intervention programs for addiction, allowing for gender-neutral interventions [2,3]. Recently, authors such as Shireley-Beaven (2020) have pointed to barriers related to the criminalization of women who use drugs in the context of the war on drugs [3,4]. However, several authors have pointed out the lack of a gender perspective in drug services, which, added to social and cultural barriers such as stigma and social penalization, results in women with addictions arriving at drug services later and with more chronic situations in terms of poverty, mental health, and histories of gender-based violence [4–10].

Three clear consequences result from the lack of a gender perspective in drug addiction treatment and services: the first is women's invisibility, which results in not accounting for their particularities and needs, which implies double victimization or re-victimization of women by drug services and associated problems, such as gender violence and trauma, which are extremely prevalent in the population of women with addictions [11] and are barriers to accessing and remaining in specific health and drug treatment services [8–10]; the second is the lack of analysis regarding the gender-related conditioning factors linked to masculinity that may influence problematic drug use. The third is that treatment for women, non-binary people, and LGBTIQ+ people, among others, is not therapeutically effective, which is against the ideals of universal accessibility, and even certain therapeutic interventions considered "neutral" from an androcentric point of view can have iatrogenic effects in these populations [7,9,10].

It is estimated that 20% of requests for drug addiction treatment in Europe come from women. As a result, most drug addiction treatment programs are designed to focus on men, ignoring the specific situations of women [9,10]. Epidemiological statistics [4] show that women with addiction problems are less likely than men to seek treatment to overcome their addiction and also have poorer progress after using services. It appears that women have a harder time than men in entering addiction treatment because they have less family and social support, face gender-based expectations related to caring for their families and children, and fear what will happen if their addictive behavior is discovered [12]. In addition, most residential services (e.g., therapeutic communities) either do not allow access to children or make regular contact with children difficult [7].

Most of the research on substance abuse treatment has shown a lack of services tailored to the needs of women and gender minorities [7], leading to an international thematic report on substance abuse treatment [4] to recommend and guide different treatment interventions needed for more effective efforts. A gender mainstreaming approach to drugs means considering gender differences and specificities in relation to the factors that determine the motivations for, different patterns of, and differential effects and consequences of drug use [13]. It also means addressing gender gaps or inequalities in access to increase uptake and reduce dropout from care services [7–9]. It is now widely recognized that the use of multifactorial systems is essential to achieving better public health outcomes [10], for example, to expand access to healthcare for poorer groups [13–17]. In this case, multifactorial means using a framework capable of examining differences in substance use problems across lifetimes between heterosexual and sexual minority men and women (and in other cases also within sexual minorities in racially diverse samples) [15,17].

The causes of inequalities can be identified by describing how the intersection of different social identities (racial/ethnic minorities, women, etc.) and the structural inequalities associated with these identities (racism, sexism, etc.) affect lived experiences (especially access to care) [17], thereby maintaining differences within the excluded group [11–22]. Furthermore, gender differences in life experiences (e.g., work preferences and family responsibilities) play an important role in changes in health outcomes, such as higher mortality in men and higher morbidity in women [22]. Gender-based violence affects women who use drugs more than the general female population when they ask for help and specifically their ability to receive assistance and treatment for drug or alcohol addiction [4,19,20]. Research and field experience demonstrate that drug misuse and dependence

are multifactorial syndromes (social, genetic, familial, educational, emotional, etc.) that interact with one another: physical and/or sexual abuse can predispose people to substance addiction, while addiction generates conditions of significant vulnerability that put people at risk of suffering violent situations and not having social support and other tools to identify these situations and get out of them [18,20–22]. It is well known that people who have suffered trauma and violence have greater substance use as a coping strategy than those who have not. Women with addictions have suffered greater traumatization than men with addictions and women in the general population, demonstrating a clear intersection between two axes of vulnerability: addiction and being a woman. The presence of both issues, gender and violence, typically results in more severe medical issues, social and familial isolation, economic dependency, and, most importantly, increased family duties, all of which pose significant barriers to access and long-term adherence to some therapies [11–22].

This study aimed to examine the factors involved in the problems for women who use drugs under treatment, analyzing several psychological and social factors (gender, substance use, mental health, source of economic support, legal situation, and sexual and domestic violence). This was undertaken by looking into the differences between women and men in the psychosocial factors that influence, and are influenced by, substance misuse.

## 2. Materials and Methods

### *2.1. Participants and Procedures*

This study used an exploratory analysis. The sample consisted of individuals participating in community therapeutic rehabilitation treatment programs run by Asociación Proyecto Hombre and Dianova's therapeutic communities. Both organizations are international references in the field of rehabilitation and are part of national and international rehabilitation groups such as the European Federation of Therapeutic Communities and the World Federation of Therapeutic Communities and other relevant forums, such as the UNODC Vienna NGO Committee. Data were collected from the participants by a trained professional using personal interviews. Written informed consent was obtained from all the participants, with a guarantee of confidentiality and anonymity. This study was approved by the UCM Deontological Research Committee; the project identification code for ethics approval is UCM PR2019_20_043.

### *2.2. Tools and Instruments*

EuropASI is the European version of the fifth edition of the Addiction Severity Index (ASI), developed in the USA by McLellan in 1990 [23]. The ASI was developed at the University of Pennsylvania in 1980 to provide a tool for collecting information relevant to the initial clinical assessment of patients with substance use problems, including alcoholism. It is intended to assist in treatment planning and/or referral decisions and may also be used in research [24]. In order to achieve this study's aim, we selected the following items from the EuropASI database:

Substance use was recorded as the number of years that the responder stated that they had taken at least one dose over their lifetime.

In order to explore social support, the following two ASI variables were selected:

Leisure social networks were explored by asking the responders, "Who do you spend most of your free time with?" The following answers were available:

(1) Family without drug or alcohol problems; (2) family with drug or alcohol problems; (3) friends without drug or alcohol problems; (4) friends with drug or alcohol problems; and (5) alone.

The number of close friends in social networks was explored by directly asking, "How many close friends do you have?"

Employment and income data were gathered by asking, "Did you receive money for your living expenses from employment during the last month?" and "Did you receive money for your maintenance from one of the following sources during the last month?"

"Family history of addiction and psychiatric diseases" data were collected from the sections "Family History" and "Family relations".

The main data on substance use were explored using the block "Substance use". "Mental Health" data were collected using the block "Psychiatric situation". For "Legal situation", data were extracted from the block with the same name and using the questions "How many times in your life have you been accused of…?" and "How many times in your life have you been convicted of…?".

Finally, "gender" was coded as female = 1 and male = 2, and "age" was coded as the actual number of years of age.

### *2.3. The Data Analysis Plan*

Data on 2173 people receiving rehabilitation treatment were collected using the EuropASI survey and obtained from PH Nemos (the Proyecto Hombre survey repository) and Minerva (the Dianova survey repository). The sample consisted of 1,850 men and 323 women, who made up 83.1% and 14.5% of the sample, respectively. The dependent variables in this study were (1) a patient's family history of addiction and mental health status; (2) main drug use; (3) drug use in their lifetime and the past month; (4) mood, physical condition, and sexual violence history in their lifetime and the past month; (5) mental health status in their lifetime and the past month (including suicide attempts); (6) legal status in their lifetime and the past month; (7) and source of income in the past month and (8) the number of patients. The factor of gender was taken as a dichotomous variable (male–female). Contingency tables were used to relate categorical variables to the factor. For interpretation, corrected standardized residuals were used (a residual less than $-1.96$ or greater than 1.96 indicates, respectively, a lower or higher proportion of expected cases under the null hypothesis). The Kolmogorov–Smirnoff normality test and Levene's test are used to ascertain whether a sample meets the statistical assumptions of normality and homoscedasticity. Since these assumptions were not met, the analysis performed was a non-parametric test. Initially, to understand whether there were gender differences in the various dependent variables, a comparative analysis of the hypotheses was performed using contingency tables for categorical variables and the Mann–Whitney U test for quantitative variables. The confidence interval used was 95%. All these analyses were performed using SPSS Statistics v27.0. The percentage of missing data is due to the fact that not all the participants completed all of the items in the questionnaire.

## 3. Results

The results presented are those that were found to be statistically significant.

### *3.1. Demographic Characteristics of the Sample*

The distribution by sex established that 84.7% are men and 15.3% women. Their average age is 37.91 years, with an interval of age ranging between 18 and 73 years. A total of 79.68% are of Spanish nationality, followed, in smaller proportions, by people with Moroccan and Colombian (2.85% each) and French and Portuguese nationality (2.14% in each case) and, in lower percentages, a minority of people from other countries (Romania, Brazil, Germany, Ukraine, Bulgaria, Russia, Belgium, and Venezuela). A total of 46.91% of people under treatment come from a city with more than 100,000 inhabitants, and 29.98% live in a city with a population between 10,000 and 100,000 inhabitants. A total of 23.11% come from rural areas. Regarding their level of education, 45.27% declare themselves as being "without education" (that is, people who have not started or not completed basic studies), and 29.93% declare only having completed "basic studies", which means that the percentage of people with low levels of academic training amounts to 75.20%. The percentage of those who report having a secondary school education stands at 17.13%. The lowest percentages are found for those who have completed a first cycle university degree or diploma (4.49%) or a second cycle university degree or bachelor's degree (3.18%).

On their demographic characteristics, there are no significant differences between men and women.

### *3.2. Family History of Addiction and Psychiatric Diseases*

More men had family members with an addiction and psychiatric disease history; specifically, significant differences were found in having a maternal grandfather with alcohol problems ($p = 0.024$); a mother with alcohol ($p < 0.001$), drug ($p = 0.050$), and psychiatric problems ($p = 0.013$); a maternal aunt with alcohol ($p = 0.020$) and psychiatric problems ($p = 0.004$); and a father with alcohol ($p = 0.038$) and psychiatric problems ($p < 0.001$).

### *3.3. Main Substance Use*

There were significant gender differences in the main substances used, alcohol (low and high) and cocaine, and no drug problem being reported ($p = 0.012$). In this regard, more women than men used alcohol (both fermented and distilled alcohol drinks), while men used more cocaine and reported no problems. There were significant differences in their lifetime use, with men using more cocaine ($p < 0.001$; 1390 men and 220 women), cannabis ($p = 0.041$; 247 men and 188 women), LSD ($p = 0.007$; 866 men and 126 women), and heroin ($p = 0.001$; 1046 men and 160 women) than women.

### *3.4. Mental Health*

Significant gender differences showed that women were more likely to report lifetime depression ($p < 0.001$); anxiety ($p < 0.001$); problems with understanding, concentration, or memory ($p = 0.010$); substance use ($p < 0.001$); suicidal thoughts ($p < 0.001$); and suicide attempts ($p < 0.001$), and the number of suicide attempts ($p < 0.001$) was higher in women than men. These differences were also present for depression ($p < 0.001$), anxiety ($p < 0.001$), drug use ($p < 0.001$) and suicidal ideation ($p = 0.025$) in the past month.

Regarding violence, significant differences showed that the women had experienced emotional abuse ($p < 0.001$), psychological abuse ($p < 0.001$), and sexual abuse ($p < 0.001$) more than the men during their lifetimes and in the past month.

### *3.5. Legal Situation*

When it came to the lifelong legal situations of the patients, there were significant differences by gender, with men being accused more of drug possession and trafficking ($p < 0.001$), property crimes (burglaries, robberies, fraud, extortion, counterfeiting of money, buying stolen goods, etc.) ($p = 0.004$), violent crimes (robberies, assaults, arson, rape, homicide, etc.) ($p < 0.001$) and other crimes ($p < 0.001$), as well as greater numbers of charges that resulted in conviction ($p < 0.001$), more accusations of disorderly conduct, vagrancy, and public intoxication ($p = 0.001$), more drunk driving ($p < 0.001$), and more traffic offenses (speeding, driving without a license, dangerous driving, etc.) ($p < 0.001$), than women. This tendency was the opposite for prostitution ($p = 0.012$), with more women being convicted for prostitution than men.

Regarding the motive for most recent incarceration, there were differences in terms of drug possession and trafficking and property crimes ($p < 0.001$), with men being incarcerated for these reasons more than women (both in terms of absolute values and proportion; Table 1). There were also significant differences in that men had been in jail over their lives for a greater number of months ($p < 0.001$) than women and also had experienced a longer stay (in months) in their last incarceration ($p < 0.001$) than women. Moreover, men had been incarcerated for a greater number of days in the past month ($p < 0.001$) and had carried out illegal activities for a greater number of days in the past month ($p = 0.016$) than women. Finally, men tended to be in treatment due to a judge's suggestion ($p = 0.038$), to be in parole ($p = 0.020$), and to have pending trials, charges, or sentencing ($p = 0.014$) more than women.

**Table 1.** Association between gender and the motive for last incarceration.

| | | Drug Possession and Trafficking | Property Crimes |
|---|---|---|---|
| Men | Count | 80 | 74 |
| | % of the total | 3.9% | 3.6% |
| | Corrected residual | 2.4 | 3 |
| Women | Count | 5 | 2 |
| | % of the total | 0.2% | 0.1% |
| | Corrected residual | −2.4 | −3 |

### *3.6. Support*

Regarding support, there were significant differences in that women had received income from colleagues, friends, and family members ($p = 0.014$) and through prostitution ($p < 0.001$) (a legal activity in Spain) in the past month more than men, while the opposite was found for illegal sources of income ($p = 0.002$). Regarding their main source of income, the proportion of men who earn money through prostitution is higher than that of women. On the other hand, the proportion of women who earn money through acquaintances and illegal sources is higher. The differences between '% inside gender' and '% of total' are very high because of the difference in size of the groups of men and women (see Table 2).

**Table 2.** Significant relations between gender and income sources.

| | | Employment | Colleagues, Friends and Family Members | Prostitution | Illegally |
|---|---|---|---|---|---|
| Men | Count | 561 | 810 | 155 | 6 |
| | % inside gender | 30.7% | 44.3% | 0.3% | 8.5% |
| | % of the total | 26.1% | 37.8% | 7.2% | 0.3% |
| | Corrected residual | 1.9% | −2.5 | 3.1 | −6.2 |
| Women | Count | 80 | 164 | 11 | 12 |
| | % inside gender | 25.2% | 51.7% | 4% | 3.5% |
| | % of the total | 3.7% | 7.6% | 0.5% | 0.6% |
| | Corrected residual | −1.9% | 2.5 | −3.1 | 6.2 |

## 4. Discussion

A multifactorial approach can identify processes [25], situations, and identities that apply to the same person, thus adapting support and treatment strategies to people's actual needs, taking into account the particularities of their circumstances and life journeys [15,20–22]. Several previous studies [6–9] have pointed to the need to consider a comprehensive approach to intervention for women with addiction, as addiction is part of a complex puzzle that must be considered holistically if treatment is to be based on ethics, effectiveness, and social justice [5,9]. This study examined several psychosocial indicators carefully to gain a deeper understanding of the differences between women and men in addiction recovery in order to collect data to facilitate evaluations of the appropriateness of existing programs and the differential interventions needed [26]. When creating an image of a woman with addiction, it is useful to obtain as much information as possible and stay realistic. It is important to emphasize that certain social categories create more stigma depending on the type of substances used and the way they are taken [13]. Specifically, for main substance use, illicit drug use is associated with higher levels of complexity and chronicity and poorer outcomes in women who use illicit drugs [19–26]. In this regard, this study found that the use of illegal drugs, particularly cocaine, cannabis, and LSD, was actually more common among men than among women, who were more likely to use alcohol. Given

that society's attitude towards alcohol is that of acceptance compared to that towards other drugs, prejudice against women in addiction should also involve more tolerance, but this is not the case [24–26]. The literature that analyzes women's reasons for using legal drugs from a gender perspective, unlike men's, is concerned with the mission of caution and not breaking the law. As a result, their problems with substance consumption become less recognized, their cases become more chronic, and treatment management becomes significantly more complex.

Regarding mental health issues, there are some stereotypes about women with addiction, such as that they are less motivated than men to continue treatment or that they tend to develop a more acute and chronic course of addiction [6,9]. This belief can influence internalized shame and create negative expectations of self-efficacy, thereby creating significant barriers to recovery [2–5]. Therefore, there is a need to close the gap between the reality for women in addiction and the public perception of them in order to eliminate prejudices [13] and to implement data-based interventions tailored to their actual needs [26,27]. In addiction treatment interventions, the complex reality of drug use must be addressed through a multifactorial approach [24–27]. Therefore, the influencing factors of addiction need to be considered and studied in order to intervene. The factors analyzed in this study included mental health, legal status, resources, sources of income, social support, and substance use [24,27]. This study showed that women are more likely than men to experience mental health problems both in life and in treatment. This is important because while some aspects of mental health improve with treatment (e.g., concentration problems and suicide attempts), other aspects do not, meaning that treatment does not solve the problem [13]. In addition, it can be argued that suicide attempts are only reduced because the therapeutic environment places patients in supervised conditions that preclude suicide attempts [7]. Research findings support this: even when women receive treatment, suicidal thoughts remain a problem [8]. Overall, the findings show that women experience more mental health problems than men, suggesting that there is an urgent need to address addiction in women and treat it differently in women than men because it is experienced more severely in women [7,8,13,24,27]. Lastly, in terms of social support and resources, when studying financial support among drug addicts, it was found that women earn more than men through social networks, probably because it is more socially acceptable for women to seek help than men [24–27]. This could be interpreted as a sign of greater social support for women; however, when examining their main sources of income, it is revealed that both men and women are involved in illegal activities, especially with women being involved in prostitution [24–27]. This is potentially due to the criminalization of women who use drugs, which is expressed in the social beliefs of these women [7,8,13].

*Limitations of This Study*

The main limitation is the quantity of missing data. This can be explained by the personal elements present in the majority of the questionnaire questions and potential hesitation in responding to them. Due to the large sample size, the presence of missing data did not lead to a significant decrease in the sample size; however, it did point to unresolved questions that may have impacted our interpretations and generalizations. Although corrections aim to manage the risk of false positives (Type I errors), excessively cautious approaches such as Bonferroni correction can result in the dismissal of genuine and significant effects. Certain researchers contend that implementing corrections, such as the Bonferroni method, on numerous dependent variables may be excessively cautious. Over-correcting can raise the chances of Type II mistakes, which could result in actual effects being overlooked. This becomes a particular issue when the dependent variables are interconnected, as assuming them to be distinct in a correction technique such as Bonferroni correction could potentially underestimate the actual connections. Additionally, we concur with other writers (e.g., Perneger, 1998) that the justification for applying the Bonferroni adjustment is no longer relevant in cases where there is a single independent variable and numerous dependent variables [28]. An outcome with, for example, $p = 0.045$,

resulting from a lone comparison between males and females on a specific dependent factor, would be considered statistically significant, regardless of whether there were ten additional results documented in the dataset that had not been examined. Nevertheless, the identical evaluation would lose its importance if we examined a different result. For all the reasons mentioned earlier, we chose not to make any adjustments to the analyses for this research [29–31].

Secondly, the sample consists of a higher number of men than women, which is not surprising given that there are more men with addictions than women. However, further research might aim to even out the ratio of males to females in comparison or to modify the lack of a control group. This imbalance will cause the larger sample to have more impact on the estimate of the pooled variance. This may introduce bias into the outcomes and result in a reduction in statistical power when compared to distributing the same number of participants into groups of equal sizes [28–30]. Nevertheless, the present distribution is internationally superior when compared to a small sample size of just 646 participants split evenly into two groups of 323 each. These imbalances are intentionally pursued, such as in case–control studies, where recruiting cases is challenging while controls are readily accessible, in setting a ratio of cases to controls (sometimes exceeding five controls per case, according to Hennessy et al., 1999) [31]. In the subject of our study, there will consistently be a greater quantity of male subjects in comparison to female subjects. In particular, if we were to employ a two-tailed Mann–Whitney test, with a significance level of alpha = 0.05 and an effect size of d = 0.2, two groups of equal sizes with $n$ = 323 each would result in a statistical power of 1 – beta = 0.698.In comparison, when using a sample size of 1850 for one group and 323 for another, the power rises to 1 – beta = 0.900 (these calculations were performed using G*Power version 3.1.9.7) [29]. Another risk associated with groups of varying sizes is the potential for biased parameter estimation, which is not present in the non-parametric Mann–Whitney test, as it is resilient in such situations. Unequal sample sizes signify that the bigger group will provide a greater number of ranks; however, this does not inherently prejudice the test outcomes. This test is able to detect variances in the median when used as a central tendency indicator, and this remains unaffected by variations in the number of samples. Some concepts mentioned in Bürkner et al. can be identified. However, the selection of exploratory analyses (even if we employ hypothesis testing to make inferences about the population) is not random. There is no alternative when the information has been collected from a cross-sectional study utilizing databases. In these circumstances (and in most situations concerning substance use in practical applications), it is impossible to create a study that explains causation. The lack of intrinsic control over the gender factor prevents the attainment of any causal objectives. The selection of variables is influenced by the data that are accessible, and the outcomes are intended to stimulate contemplation rather than establish a theoretical framework.

Another constraint is the absence of individuals who are part of the LGBTIQ+ community. There is evidence indicating that therapy for women, non-binary individuals, and LGBTIQ+ individuals, among others, may not be as therapeutically beneficial as desired, contradicting the principles of universal access. However, further research is needed to delve deeper into this issue as a potential future direction in this field.

A limitation of great importance is that this was a group of people who are already receiving treatment, with a lack of a control group, meaning that our results do not directly address what factors may prevent women from seeking treatment. We can identify multiple concerns. In future research, we will examine the subject further; however, it is not feasible to draw conclusions in this direction based on the data, the sample, and the analysis conducted in the current study.

Ultimately, the data analysis carried out indicates substantial variance and the orientation of these variances but not the root reasons behind them, however. Further investigation should be based on this information to explore the reasons behind this variance, with the aim of constructing a more comprehensive model regarding the risk factors and protective elements related to addiction for both males and females.

## 5. Conclusions

Addictions are complex matters that entail many factors, including social and psychological ones. This is why interventions should be comprehensive and consider all of them to be effective and adequate. The aim of this study was to investigate the differences between men and women in addiction in several domains related to drug use and social inclusion using a cross-sectional analysis [24–26]. The findings suggest that women have special needs and vulnerabilities that need to be considered when they receive treatment, but this is not currently the case. This demonstrates the need for women-specific drug recovery programs and not just these but also programs tailored to the needs of each woman's unique situation [25–27]. Given the many factors influencing substance consumption and evidence that fixed treatment options do not adequately address the complex realities of substance abusers, multifactorial approaches are urgently needed in any intervention [24,27]. Future research directions should focus on further analysis of the causes of gender differences in mental health, crime, social support, and substance abuse, as well as the causes of drug use in men and women [24,27].

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