

Do women with complex alcohol and other drug use histories want women-only residential treatment?

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ABSTRACT

Background Women-only addiction services tend to be provided on a poorly evidenced assumption that women want single-sex treatment. We draw upon women's expectations and experiences of women-only residential rehabilitation to stimulate debate on this issue. **Methods** Semi-structured interviews were undertaken with 19 women aged 25–44 years [currently in treatment ($n = 9$), successfully completed treatment ($n = 5$), left treatment prematurely ($n = 5$)]. All had histories of physical or sexual abuse, and relapses linked to relationships with men. Interviews were audio-recorded, transcribed verbatim, coded and analysed inductively following Iterative Categorization. **Findings** Women reported routinely that they had been concerned, anxious or scared about entering women-only treatment. They attributed these feelings to previous poor relationships with men, being more accustomed to male company and negative experiences of other women-only residential settings. Few women said that they had wanted women-only treatment, although many became more positive after entering the women-only service. Once in treatment, women often explained that they felt safe, supported, relaxed, understood and able to open up and develop relationships with other female residents. However, they also described tensions, conflicts, mistrust and social distancing that undermined their treatment experiences. **Conclusions** Women who have complex histories of alcohol and other drug use do not necessarily want or perceive benefit in women-only residential treatment.

Keywords Alcohol, drugs, gender, intersectionalist feminism, post-structuralist feminism, qualitative, residential rehabilitation, residential treatment, service user involvement, women-only treatment.

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INTRODUCTION

Differences between women and men who use alcohol and other drugs are widely documented. Studies show that women have different patterns of substance use from men [1–6], are more likely to be involved in sex work [7] and have more extensive histories of trauma and abuse [8,9]. Women may also be less likely to initiate treatment for substance dependence [2,7,10] and are more likely to encounter barriers (for example, stigma, judgemental staff attitudes, lack of childcare and fear of losing custody of children) when they do seek help [10–13]. By the time women access addiction services, there is evidence that they tend to have greater needs than men, including more psychological distress and mental health problems, more

interpersonal conflicts and family-related issues and more problems associated with lack of employment and vocational skills [14].

Authors have often argued that mainstream addiction treatment services cater primarily for men and overlook the needs of women [1,2,8,15,16]. In response, women-only services and gender-responsive services have been introduced in many countries. These services commonly provide childcare, offer support with past experiences of trauma and focus on women's strengths and skills rather than their deficits [1,2,16,17]. They also often adopt relational approaches to treatment, especially when working with women who are disconnected from family and friends, have low self-worth and are experiencing difficulties maintaining supportive healthy relationships because of

repeated past abuse [16]. Relational ways of working recognize the importance of interactions with others in shaping daily experiences and emphasize the role of fulfilling relationships in long-term emotional wellbeing and recovery [16,17].

Despite widespread acceptance of the need for women-only services, there is limited robust evidence of their effectiveness. Researchers have encountered methodological and practical challenges, relating particularly to the diversity of women-only interventions available and the lack of standardization when implementing women-only therapy [18,19]. This has made comparisons across services difficult; a problem compounded by the difficulty of randomizing women to specific treatments [17,20–22]. Meanwhile, evaluations have shown mixed results. Some studies have found that women-only treatment is as effective [23,24] or more effective [20,25–27] than mixed-sex treatment at reducing substance use [20,23,25–27] and crime [24–28], and that women-only residential treatment is associated with longer stays, higher completion rates [14] and increased out-patient aftercare following treatment [19]. In contrast, other studies have reported no significant differences in outcomes between women-only and mixed-sex treatment [10,29], or have concluded that any improvements in outcomes from women-only treatment are not sustained over time [26,28].

Few studies have explored women's personal accounts of single-sex treatment and again findings are inconclusive. Female clients have sometimes endorsed women-only treatment settings as places of safety, support and understanding [10,12,30]. Specifically, they have reported that women-only services help them to feel at ease, facilitate honest discussions about sensitive or women-specific issues [8,12,30–32], enable them to relate to other clients through shared experiences [12,30,32] and increase the focus on 'recovery', as the absence of men limits opportunities for sexual tension [6,31]. Other clients of women-only services have described all-female treatment more negatively, stating that they found it overwhelming and unrepresentative of the mixed-sex world, felt uncomfortable around, or mistrustful of, their female peers and disliked the fact that other clients gossiped or were 'bitchy' [32].

One potential explanation for these contradictory findings is that there is no universal experience of being a woman who uses alcohol or other drugs and consequently no predictable set of treatment wants, needs or goals. As post-structuralist feminists and intersectionalist feminists have argued, women have very diverse lives and experiences. These are shaped and constrained by gender, but also by other complex interacting factors, such as race, class, culture, income, education, age, ability, sexual orientation, immigration status and geography, etc. [33–36]. In addition, women and men often share experiences of substance use and related problems and so can have very

similar treatment needs [7]. Consequently, women who use substances may derive benefit from a range of services, including single and mixed-sex services, so long as these are provided in a gender-sensitive manner [7].

The aim of this paper is to stimulate debate around the common, but poorly evidenced, assumption that women with complex alcohol and other drug use histories want women-only treatment. Our starting-point is a qualitative study designed to evaluate a women-only residential treatment service located in England, UK. Data collection and preliminary analyses indicated that many of the female clients interviewed were initially very negative about being treated in a women-only setting and sometimes expressed hostile views about their female treatment peers. Rather than ignoring this finding as an 'inconvenient truth' [37], we decided to analyse the data more systematically.

METHODS

Setting

The women-only service was part of a larger organization that offered both mixed-sex and separate women-only residential rehabilitation treatment and additional community-based services. The parent organization had been in existence for many years and was abstinence-based. It had charitable status and was funded through a range of donors and grant-giving bodies. The women-only residential service catered for women older than 17 years who were experiencing problems with alcohol or other drugs, had a history of physical or sexual abuse and had a pattern of relapse linked to their relationships with men.

At the time of the study, the women-only service provided treatment for up to 10 women in one house. There was also a small family flat that enabled the women to have occasional overnight visits by children. Access to the women-only residential service was by referral and assessment only. Although some women had specifically requested women-only treatment when initially seeking support, most had been referred there by professionals who had determined that all-female treatment would be most suitable for them given their histories and current circumstances. Following referral, all women were assessed by staff from the parent organization. The organization's staff considered each woman's substance use, relationship history and experiences of violence and abuse before deciding whether to place her in the mixed-sex or women-only residential setting. The extent to which women had choice in the service they attended was unclear.

The women-only residential service was staffed 24 hours a day by an all-female team and men were not permitted on site. Women were required to have completed detoxification on admission and to remain abstinent from all substances during their stay (typically 6 months). Residents shared bedrooms and maintained collective

responsibility for cleaning, buying groceries and preparing meals. They also attended daily treatment groups and were each assigned a trained, therapeutic worker. The treatment programme was gender-specific and included trauma recovery groups, eating recovery groups and programmes for women who had experienced domestic violence or had backgrounds of sex work. Consistent with the service's relational therapeutic approach, residents were expected to work together to address their substance use, increase their awareness of others and learn how to form healthy relationships. Additional educational and recreational activities were provided at a centre shared with residents from the organization's mixed-sex services.

Data collection

A University Research Ethics Committee approved the study and data were collected between April and July 2015. Two female qualitative researchers visited the women-only service to meet residents informally, introduce the research and answer any questions. Residents with an interest in being interviewed were encouraged to speak to a member of staff who then passed their names to the research team. Staff additionally approached former residents of the women-only residential service and sought permission to pass their contact details to the researchers. The researchers then purposively sampled current and former residents (ensuring diversity in terms of age and substance use histories) and invited them to interview.

Before any data were collected, the researchers assured participants of their anonymity and obtained written informed consent. Interviews then took place in private either at the women-only service or in community services. The interviews were semi-structured in format and guided by a topic guide that covered, *inter alia*, participants' backgrounds, substance use and their expectations and experiences of the women-only residential service. Each interview was audio-recorded and transcribed verbatim. All participants received a £10 gift voucher as a gesture of thanks for their time.

Data management and analyses

Data management and analyses were based on Iterative Categorization [38]. First, several interview transcriptions were read, key issues were noted and a coding system comprising main and subcodes was developed. The coding system and all transcriptions were entered into MaxQDA (Berlin, Germany) software, which is designed to assist qualitative data analysis. All transcriptions were then coded by assigning sections of text electronically to the relevant code or subcode. Codes and subcodes containing data on the women's expectations and experiences of women-only treatment were next exported from MaxQDA

into Microsoft Word documents. These Word documents were subjected to line-by-line analyses, generating inductive themes and patterns which were grouped into a coherent overall structure [30]. Findings are reported below and illustrated using verbatim quotations, labelled with each participant's pseudonym, age, substance(s) used pre-treatment and treatment stage at the time of interview.

Participants

Nineteen women, aged between 25 and 44 years, were interviewed. Nine were currently in treatment at the women-only residential rehabilitation service, while 10 had moved on (five had completed the treatment successfully and five had left prematurely; 'dropped out'). Seventeen participants were European (16 white British) and two were of mixed ethnicity. Fourteen were heterosexual, four bisexual and one lesbian. Thirteen were mothers, all with non-resident children.

Participants' substance use ranged from 2 to 25 years; seven had entered the women-only service for treatment for illicit drugs, seven for alcohol and five for combined illicit drugs and alcohol. Eight had received residential treatment previously (six in a mixed-sex service and two in a women-only mother and baby residential rehabilitation unit). Others had been treated previously in short-stay mixed-sex residential detoxification services. All had been physically or sexually abused by men; nearly all reported mental health issues including anxiety, depression, post-traumatic stress disorder, self-harm and suicide attempts; many had experienced homelessness previously and had stayed in single-sex hostels; some had sex worked; and several had been in prison.

FINDINGS

Expectations of women-only treatment

Concerns and anxieties

Participants reported repeatedly that they had felt anxious or concerned prior to moving into the women-only residential service, with some stating that they had felt 'scared' or 'terrified' at the idea. Participants elaborated that they had been worried that women-only treatment would be 'harder' than mixed-sex treatment and that they would not 'get along with' other residents, whom they feared would be 'bitchy' and 'reject them'. Many had also anticipated that it would be difficult to hide their true feelings in women-only treatment, noting that women are more perceptive than men:

I thought this [women-only treatment] is going to be a nightmare. But I think everyone does... Everyone says it when they come in, [that they] get on better with men. Because you get used to being around men more.

They're easier, aren't they? Simple-minded. You think that women are going to be bitchy (Faye, 33 years, alcohol, current resident).

When probed further, participants identified other factors underlying these negative expectations. Some referred to personal histories of abuse perpetrated by, and poor relationships with, other women (including mothers and other female family members), being bullied or rejected by girls at school and never having really had female friends. Several participants with a history of sex work also stated that they viewed women as 'competition' and 'the enemy', adding that they did not feel comfortable around women and tended to be mistrustful of them.

Although everyone interviewed had been physically or sexually abused by men, all but one reported that they were more accustomed to spending time with men than with women and so felt more at ease around men. In particular, they stated that men were less judgemental and 'easier' to get on with than women, and they expressed concerns that they would feel vulnerable without the 'protection' of male company. Some added that they knew how to behave in order to be accepted by and to manipulate men, whereas they did not know how to behave around women:

I don't get on with females. I get on with men and that's, I don't know, mainly because I can manipulate them probably. Like you can't manipulate a female (Marsha, 30 years, drugs and alcohol, current resident).

Participants also associated their negative expectations of all-female residential treatment with previous bad experiences of other women-only residential settings, including homeless hostels and prisons. Some stated that women's homeless hostels were 'chaotic' places where female residents were 'malicious' to each other and stole from one another. Similarly, they described women's prisons as places where dishonesty and intimidating behaviours were commonplace and a 'don't grass' (inform on others) culture prevailed. In consequence, participants who had spent time in either hostels or prisons often reported that they had learnt to 'keep themselves to themselves' and to limit their interactions with other women.

Anticipated benefits

Although participants did not generally welcome the prospect of women-only residential rehabilitation, a few stated that they had been positive about attending an all-female treatment setting. Elaborating on this, women sometimes explained that they had hoped to make some female friends and had believed that it would be 'easier' to talk openly about their experiences without men present. Specifically, they voiced concerns about sharing their histories of sexual abuse or sex work in front of men, noting that they were afraid of appearing vulnerable:

I thought I'd be able to benefit more from here in a woman's house because... I have experienced domestic violence, and I experienced rape and stuff. I don't really think that, well me personally, it's going to make me feel comfortable talking about that around men (Fiona, 31 years, alcohol, current resident).

Several other participants described how they had previously had negative experiences in mixed-sex residential addiction treatment, which they believed would not be repeated if they went to an all-women service. These negative experiences had included feeling unable to disclose sensitive personal issues in mixed group therapy, particularly after male residents had become upset when women had shared their experiences, and being 'distracted' by romantic relationships with male residents. Alice, for example, remembered how an intimate relationship with a male resident in a mixed-sex service had prevented her from engaging fully with one therapeutic programme:

I got into an exclusive relationship. Yeah, had a great time... had a very nice distraction the whole time I was there (Alice, 32 years, drugs, current resident).

A few participants also reported that they had gone into the women-only service, even though they had not 'wanted' to do this, because they had believed that they 'needed' to be in an all-female environment to address their addiction and related problems. In this regard, participants reasoned that they had needed to be away from men in order to get to know themselves, understand their substance use and past relationships and learn how to develop meaningful and balanced relationships in the future:

I get on with men better, because I have this whole rejection issue with women. But I couldn't have gone into an environment with men in it... I wouldn't have come if it wasn't for the fact that it was an all-women's unit, I wouldn't have even entertained the idea, because the worst issue for me has been men (Christine, 34 years, drugs and alcohol, current resident).

Experiences of women-only treatment

Valued aspects

Once in women-only treatment, participants' accounts of their experiences tended to be more positive than their pre-treatment expectations. Mostly, they agreed that the absence of men had helped them to share their lives, feelings and emotions, and had enabled them to 'speak freely' and 'open-up' about issues, often for the first time:

There's like a closeness that I think there wouldn't be with men in there. I think we'd all be quite different if there were males around. We can share a lot more with each other... You know what it's like when women are

together, it's totally different... The depth we can share stuff too... [I've] never experienced anything like it (Alice, 32 years, drugs, current resident).

Participants commented on how listening to other residents 'like me', who had similar personal histories of abuse, sex work, strained relationships and child custody issues, had aided them to feel understood, less alone, less ashamed and less guilty. Some also reported that hearing other women's experiences had helped them to learn about themselves and created a group identity that had encouraged them to form relationships with, and support, one other:

You realize that you're not the only person that's been through certain situations and that probably made it a lot easier to talk about certain things, especially when other women come forward and talk about things in group. And you're like, 'Oh my God, that's happened to me too!' (Angela, 27 years, drugs, completed treatment).

In addition, participants sometimes explained how routine activities—cooking and eating meals with other women, sharing bedrooms, watching television in the evenings and 'having a laugh'—generated friendships. Being complicit in breaking service rules together or keeping secrets for one another (including secrets about romantic relationships with men in the organization's mixed-sex service) were also behaviours that bonded women together. Meanwhile, some former residents confirmed that friendships made while in the women-only service endured, as they were still in contact with fellow residents several months after they had left treatment.

Lastly, participants often reported that they felt comfortable and relaxed in the women-only house, adding that this was reflected in their appearances and clothing. Thus, they stated that it felt good to dress casually and without make-up, safe in the knowledge that there were no men to 'impress' or to 'ogle' at them:

You could just walk around in your pyjamas... It just felt so relaxed. You can just walk downstairs in your nightie [nightwear] and go and put the kettle on... You couldn't do that in a mixed house. You just felt more at home, you know. And you could just, like, women's talk, fun talk. You can't do that when you're with men (Suzie, 43 years, alcohol, left treatment prematurely).

Challenges

Valued aspects of living in the women-only house were, however, undermined by negative experiences of the all-female environment. In particular, participants said that living in close proximity to other women felt overwhelming and intrusive. Being constantly around other women was

described as challenging, particularly for those who were not accustomed to female contact:

I didn't feel comfortable staying in the same room as another woman that I didn't actually know. That was very uncomfortable (Kerry, 32 years, alcohol, left treatment prematurely).

Some participants reported that their previous histories of abusive and problematic relationships with women made it difficult for them to trust other female residents. This was exacerbated when participants had actually opened up and confided in other women, but those women had then 'let them down' by repeating confidential information to others. Here, the service ethos of 'being honest' and 'looking out for one another' could be especially confusing. This was because staff encouraged all house residents to share any concerns that they had about fellow residents. However, disclosing personal information about others could be perceived as being deceptive and 'two-faced':

I've got really bad trust issues... I don't trust no one. I've been told that I've got to open-up more... And at the moment I can't, because I've got no trust in them [other female residents] (Becky, 30 years, drugs, current resident).

In addition, women described not 'getting on' with each other, tensions and conflict. Breaking rules, using substances and having romantic relationships with men were all identified as sources of 'bitchy' arguments, 'scraps' and 'fights'. For example, one participant described arguing with another female resident after they had both had a sexual relationship with the same man from one of the linked local mixed-sex services. In other cases, participants said that they had been intimidated, bullied or ostracized by other women, and this had left them feeling alone and unsafe. Sometimes, the conflicts were so severe that they had left the women-only service before completing their treatment:

Going down to meet the women was just terrifying. It wasn't a nice atmosphere... I've never been in a place like it... I was there for two months and every day, every day, I wanted to leave (Sharon, 32 years, drugs, left treatment prematurely).

Compounding these negative experiences, participants voiced discomfort about living among women whom they perceived as 'different' and 'not like them'. They noted that other women in the house had very diverse backgrounds, life-styles and substance use histories, and this created divisions and a tendency for groups of residents to distance themselves from others. Most notably, women in treatment for alcohol tried to avoid illicit drug users who had sex-worked and women who did not want contact with men dissociated from those who continued to have heterosexual

relationships. Again, this distancing led to some women feeling lonely, isolated and unable to 'fit in':

There's people who have come off the street, come out of prison, and stuff like that. But my home life was quiet, with my partner... Some of these people that have come in... didn't come from where I come from... They were all ex-sex workers... That's not me... You don't get on with everyone, obviously, you keep your distance from some people (Stacey, 29 years, alcohol, left treatment prematurely).

DISCUSSION

Our participants expressed anxiety routinely about entering all-female treatment and they often related this to their previous poor relationships with women and negative experiences of other women-only residential settings, including hostels and prisons. Nonetheless, some had anticipated that they would make better progress in women-only treatment compared to mixed-sex treatment or had felt that they 'needed' to be away from men in order to address their substance use and related problems. Once in women-only treatment perceptions tended to be more positive, with participants often stating that they felt safe, supported, relaxed and understood, as well as able to open-up and develop relationships with other women. However, they reported tensions and conflicts (sometimes serious), and emphasized that they felt overwhelmed and unable to trust other women and wanted to keep their distance from women whom they perceived as different from themselves.

There are very few in-depth studies of women's views and experiences of women-only treatment, and ours is the first, to our knowledge, to explore whether or not women actually wanted to be treated in a women-only residential setting. Our findings are broadly consistent with the limited extant literature, which has also found that women report both positive and negative aspects to being treated separately from men [6,8,10,12,30–32]. More significantly and unexpectedly, our data revealed that women were routinely fearful and negative about entering women-only treatment, expressing concerns that treatment would be harder without the presence of men. While our participants tended to become more positive after treatment entry, they continued to identify challenges relating to the all-female environment and these caused some to leave the service prematurely.

Our data, derived from interviews conducted with only 19 people from one women-only service in England, have obvious weaknesses. All the women reported complex histories of substance use, relationships with men and abuse—so were not necessarily typical of substance-using women more generally. Our small sample size prevented

us from identifying differences between subgroups of women and our findings might have varied if we had conducted our research in another all-women service, especially a service with a different treatment approach or physical structure (e.g. single bedrooms or more space for children to visit). Also, we would probably have found some similar treatment experiences if we had conducted interviews in a mixed-sex residential setting. Indeed, bonding, forming friendships, sharing personal stories but also tensions, arguments, conflict, mistrust, loneliness and social distancing have all been reported in the literature on mixed-sex residential treatment [39,40]. Lastly, we interviewed women cross-sectionally, at different stages of treatment. Interviewing the women longitudinally (before, during and after they entered the service) would have provided clearer insights into if and how their views changed over time.

Given the above limitations, our findings cannot be generalized to other services and settings. Nonetheless, they still raise important issues that merit further consideration and debate. First, any assumption that women (including those who have histories of difficult or abusive relationship with men) will inevitably want and perceive benefit in women-only treatment needs to be questioned. The literature documenting the importance of women-only treatment has tended to focus upon the differences between men and women in terms of their substance use and treatment requirements. However, there is also a body of work, often drawing upon post-structuralist feminism and intersectionalist feminism, that highlights how women who use substances have very diverse needs and experiences [7,41–44]. Further, the similarities between women and men who use substances—in terms of their life problems and vulnerabilities—often outweigh the gender differences [7,44]. Our findings reinforce this, revealing how women in treatment often report that they relate better to men, mistrust each other, argue, fight, distance themselves from each other and position themselves in a hierarchical relationship to other women in order to reinforce their differences.

Secondly, our analyses cause us to critically revisit the concept of user involvement in treatment decision-making. User involvement has been advocated widely in many areas of health care, including alcohol and other drug treatment [39]. The findings we present here reveal that some women may be adamant that they do not want a particular type of service, and then later come to recognize the benefits. This does not, however, mean that professionals 'know better' than their clients and so should be at liberty to allocate them to single-sex treatment against their will. Indeed, some of our participants continued to be negative about women-only treatment long after treatment entry. Instead, our findings remind us that user involvement comprises a wide range of

activities, including information-giving, consultation, partnership, delegated power and user control [45–48]. Thus, user involvement does not mean that women need to make decisions about their own treatment in isolation. It recognizes that good decisions can be made if professionals and clients share knowledge and discuss treatment options together [49].

Women-only residential rehabilitation treatment is not, it seems, always desired or valued by women; some actively resist it. Further research is now needed to consider whether and to what extent our findings are replicated in other women-only residential services and in women-only community services. If this proves to be the case, studies can be undertaken to investigate more systematically the characteristics and circumstances of women most and least likely to benefit from women-only residential treatment, and the reasons for this. Parallel studies may also be undertaken within services catering only for men. In the absence of this additional research, it is important to consider whether or not we can make any practice recommendations based on our own limited data. We suggest that we can. As findings from our study are consistent with post-structuralist and intersectionalist feminism and the literature on user involvement, there is theoretical support for our analyses and we are therefore confident in concluding with some tentative suggestions for service delivery.

CONCLUSIONS

Like all treatment modalities, women-only services will have strengths and weaknesses, and it seems strategically sensible to be open about these rather than to promote women-only services as a panacea for women just because they are the same sex and report a certain constellation of pre-existing experiences and needs. Providing potential clients of women-only residential treatment with as much information as they want, permitting them to air their hopes and concerns about living in an all-women environment, arranging for them to speak to former residents of all-female services about life in single-sex treatment and explaining how some women become more positive about women-only services after experiencing them first-hand could all enable women to make more informed decisions when considering their treatment options. Meanwhile, discouraging female clients in residential rehabilitation treatment from automatically mistrusting or judging women who seem in some way different from themselves and instead encouraging them to understand and respect the diversity of women's lives and experiences, as well as the characteristics and experiences they share, should help to increase the relational potential of single-sex provision.

Declaration of interests

J.N. is part-funded by, and J.S. is supported by, the National Institute for Health Research (NIHR) Biomedical Research Centre for Mental Health at South London and Maudsley NHS Foundation Trust and King's College London. J.S. is a NIHR Senior Investigator. J.N. receives honoraria and some expenses from *Addiction* journal in her role as Commissioning Editor and Senior Qualitative Editor. J.S. is a researcher and clinician who has worked with a range of types of treatment and rehabilitation service-providers. He has also worked with a range of governmental and non-governmental organizations, and with pharmaceutical companies to seek to identify new or improved treatments from whom he and his employer (King's College London) have received honoraria, travel costs and/or consultancy payments. This includes work with, during the past 3 years, Martindale, Reckitt-Benckiser/Indivior, MundiPharma, Braeburn/MedPace and trial medication supply from iGen. His employer (King's College London) has registered intellectual property on a novel buccal naloxone formulation and he has also been named in a patent registration by a Pharma company as inventor of a concentrated nasal naloxone spray. For a fuller account, see J.S.'s web-page at <http://www.kcl.ac.uk/ioppn/depts/addictions/people/hod.aspx>. C.N.E.T., A.D.M. and C.T. have no disclosures to report.

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