Commentaries on Neale et al. (2018)

WOMEN-ONLY TREATMENT? EPISTEMOLOGIES OF IGNORANCE, INTERSECTIONALITY AND THE NEED FOR A FEMINIST EMBODIMENT APPROACH

The idea that women-only addiction services are best for women tends to be based on weak evidence, assuming that all women want single-sex treatment. Neale et al. reveal important points about women’s expectations and experiences of women-only treatment which needs further exploration. This commentary offers theoretical support for their analysis.

Neale et al. [1] discuss that the somewhat time-honoured belief that women-only addiction services are best for women tends to be based on weak evidence, assuming that all women want single-sex treatment. Employing a small empirical study, the authors reveal important points about women’s expectations and experiences of women-only treatment. These points reveal this belief as not only equivocal, but also needing more exploration. Furthermore, given that their findings are consistent with ‘post-structuralist and intersectionalist feminism’, the authors contend that there is theoretical support for their analysis.

Neale et al. [1] would find further theoretical support in Gendering Addiction [2], where the authors trace how the knowledge-making practices present in addiction research and treatment have made the field resistant to examining the gendered, classed and racialized power differentials that structure women’s lives. These power differentials need to be acknowledged, otherwise what we want to know about women’s specific needs will continue to be unknown. Feminist knowledge production is a promising route for overcoming pervasive epistemologies of ignorance that prevail in the addiction field and for supporting post-structural and intersectionalist feminism. The notion of epistemologies of ignorance [3,4], used in the context of the women’s health movement, shows that this resistance movement was concerned not only with the circulation of knowledge but also ignorance. Indeed, ‘to fully understand the complex practices of knowledge production and the variety of factors that account for why something is known, we must also understand the practices that account for not knowing... our lack of knowledge about... [A]n account of the practices that resulted in a group unlearning what was once a realm of knowledge... [means] we must... examine the ways in which not knowing is sustained and... constructed... Any effort to understand ignorance [must] recognize that it is a complex phenomena which, like knowledge, is situated’ (p. 2) [3].

In the context of the addiction field, these ideas help researchers to recognize not only how ignorance is embedded in addiction research and treatment, but also how addiction knowledge is constructed and produced by both knowing and not-knowing practices. In effect, multiple epistemologies of ignorance work along gendered, sexualized, classed and racialized lines to make knowing what women need difficult to discern in the addiction field—an issue raised by Neale et al. [1] when they refer to ‘respecting the diversity of women’s lives and experiences’ (p. 12).

While Neale et al. [1] explore women’s expectations and experiences of treatment, their work would also benefit from focusing upon embodiment—recognizing how social power differentials position women’s bodies and acknowledging the pervasive epistemologies of ignorance that structure knowledge practices. Epistemologies of ignorance that persist within the addiction field can be remedied through an approach rooted in feminist knowledge of embodiment. For example, the vernacular of drug use relies upon an individualistic, mechanistic view of a gendered body, a view that goes hand-in-hand with the notion of ‘embodied deviance’, ‘the scientific claim that bodies of individuals classified as deviant are marked in some recognizable way’ (5, p. 2). Regardless of how deviant behaviour is defined, it manifests itself in the substance/materiality of the ‘deviant’ s body. Simply, individuals who deviate from the ideal are not only deemed to be socially and morally inferior; their social and moral trouble-making is also embodied. As a form of ‘embodied deviance’, drug use ‘marks’ bodies of individuals and determines their low social status and lack of moral agency. Even within the women’s movement, women’s drug use is considered as an emblematic failure for women [6], the guardians of morals [7]. Addicted women typically occupy subordinate social locations and are often passed over by feminist movements focusing upon health equity or reproductive rights due to the stigma and moralizing surrounding drug and alcohol use which exist in feminist movements. Neale et al.’s [1] implicit sympathy for a relational approach to treatment has merits, in that this approach helps to generate empathic responses which have political implications in the addiction field [8].

Recently, Campbell & Herzog [9] argued that bodies become ‘interpretable’ culturally and politically and in response bodies are changed—‘bodies are... shaped to carry the effects of a gender order’ (9, p. 254). They demonstrate that gender and other categories such as race, ethnicity, age, class, etc. are intersecting categories assigned to bodies. This idea is implicit in Neale et al. [1]
and could be incorporated usefully into all addiction research and treatment.

Declaration of interests
None.

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References

WHAT DO WOMEN WANT? WOMEN WANT SERVICES TAILORED TO THEIR NEEDS

Service-user needs and preferences should be used to integrate substance abuse treatment more effectively with other health and social services.

‘What do women want?’ is a question asked by philosophers and pundits over the ages and raised again by Neale et al. [1]. In raising the question, they seek to stimulate the debate around the ‘common’ assumption that women with complex alcohol and other drug use histories want women-only treatment. Based on focus-group interviews with 19 women (nine currently in treatment, five who completed treatment successfully and five who left treatment prematurely), they conclude that ‘women who have complex histories of alcohol and other drug use do not necessarily want or perceive benefit in women-only residential treatment’.

Without debating how ‘common’ is the assumption that women want women-only treatment, this commentary is focused on the paper’s contributions and opportunities it provides for extending understandings into other areas.

The paper makes a significant contribution to the literature by pointing to the desirability of taking account of service user preferences. In this study, they give voice to women substance users in a way that is relevant to increasing user involvement in treatment decision-making. The growing literature on user involvement in health-care decisions shows that it requires information-sharing that both (a) specifies an intervention’s risk as well as benefits and (b) acknowledges the limitations of human information processing [2]. We have little evidence of user-involvement—or even interest in user-involvement—in treatment decision-making in substance abuse treatment. A typical approach has been a ‘cookie cutter’ one. Service-user preferences and needs are not assessed or discussed and the user receives whatever treatments or services are available. This paper reminds us of the value of assessing service needs and preferences.

The service-user preference evaluated in this study was for a women-only versus mixed-gender residential service model. Although we have no literature on user preferences for services organized by gender, we have evidence showing that in non-residential settings women-only treatment is as effective or more effective than mixed-sex treatments at reducing substance use and crime (e.g. [3,4]). In residential programs, women-only programs are associated with longer stays, higher completion rates and increased post-treatment after-care [5]. Further, a number of nomothetic analyses show higher levels of client satisfaction for women-only programs (e.g. [3]).

Further, although we have no literature on service user preferences for programs organized by gender, we have evidence that service users, when asked, can identify their service needs readily. Also, when they receive the services they say they need (i.e. when service receipt is matched to service need), they are more likely to remain in treatment, to reduce post-treatment substance use and to be more satisfied with treatment [6,7]. This effect is especially pronounced for women. Overall, this research is part of a growing literature on service integration: evidence that substance abuse treatment is more effective when health, mental health, parenting, vocational, housing and legal issues are addressed along with substance abuse issues [8,9].