

Gender-Responsive Treatment for Women With Substance Use Disorders

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About WATCH: WATCH, which stands for Women And Their Children Heal, was established in 2002 to create a state-wide forum for addressing the gender-specific treatment needs of women with substance use disorders. WATCH's mission is to enhance gender-responsive alcohol and other drug treatment programs and to advocate for the protection of mandated services for women, pregnant and parenting women, and their children. WATCH is comprised of leaders from various agencies across the Commonwealth of Pennsylvania, which provide services either exclusively or primarily to women, or which offer women-centered programming within the agency.

To this end, WATCH has adopted the Gender Responsive Treatment Principles described in the 2009 preview copy of the TIP (Treatment Improvement Protocol) on "Substance Abuse Treatment: Addressing the Specific Needs of Women," developed by the Center for Substance Abuse Treatment (CSAT), part of SAMHSA within the U.S. Department of Health and Human Services.

Gender Responsive Treatment Principles

- Acknowledge the importance and role of socioeconomic issues and differences among women.
- Promote cultural competence specific to women.
- Recognize the role and significance of relationships in women's lives.
- Address women's unique health concerns.
- Endorse a developed perspective.
- Attend to the relevance and influence of various caregiver roles that women often assume throughout the course of their lives.
- Recognize that ascribed roles and gender expectations across cultures affect societal attitudes toward women who abuse substances.
- Adopt a trauma-informed perspective.
- Utilize a strengths-based model for women's treatment.
- Incorporate an integrated and multidisciplinary approach to women's treatment.
- Maintain a gender-responsive treatment environment across settings.
- Support the development of gender-competency specific to women's issues.

Introduction

For years, research on addictions treatment was focused on men. Finally, in the 1980's, the research caught up with what providers of women's drug and alcohol treatment programs knew for a long time – gender matters. The needs of men and women are different and creating a healing environment for women means designing program services that reflect their lives and respect these differences.

Women face issues, which if not unique, are experienced differently as a group when compared to men. In addition to the important differences between men and women with regard to the physical effects of substance use, there are also social and emotional factors that play a role in the onset and progression of addiction in women. Women often face unique barriers to treatment – both systemic and personal. Systems-related issues may include a lack of resources, while personal barriers to treatment are frequently related to the stigma associated with women who experience alcohol or other drug problems. All of these factors impact engagement and retention and ultimately the effectiveness of treatment.

The purpose of this document is to offer agencies and programs that serve women with substance use disorders across the continuum of care a set of sample standards and recommendations for treating addiction in women throughout their lifespan. These recommendations serve as a guide for creating quality gender-responsive treatment and support services for women within a biopsychosocial context, ultimately enhancing their outcomes. The information and recommendations presented here are based on research, reflect best practices in the treatment of addiction in women, and are grounded in women's experiences.

Once considered primarily an issue affecting men, a 2003 National Survey on Drug Use and Health (NSDUH) report indicated that 61% of females ages 12 and older used alcohol and 12% used an illicit drug in the preceding year. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), 6.2 percent of females ages 12 and older were classified with substance dependence or abuse in 2004, but only .9 percent of females received treatment that year. And, according to data from the NSDUH, 5.1 percent of adult women (approximately 5.9 million) were in need of alcohol treatment in 2008.

For women, substance abuse is often linked to early childhood trauma, sexual assault, unwanted pregnancies, child abuse and neglect, and the spread of HIV and AIDS (Carter, 2002a; Carter, 2002b; Chasnoff, Neuman, Thornton & Callaghan, 2001; Nelson-Zlupko, Kauffman, & Dore, 1995). For minority women and other special populations, the issues are even more complicated. In order to be effective, providers must understand these relationships and the impact of race and culture, and offer women treatment that is not only sensitive to their needs, but reflects their lives, paying particular attention to these issues.

Why a Gender-Responsive Approach to Women's Treatment?

Until the 1960s and 1970s, alcoholism and other drug addictions in women were generally not addressed, not because women were not using or abusing alcohol or other drugs, but because society had a difficult time admitting that they were. Stephanie Covington says, "The invisibility of women's

substance abuse often blinds us to the distinctive patterns of women’s abuse and their distinctive needs in recovery.”

In an effort to overcome the denial about substance use in women, some women began to talk about subjects often considered taboo, including the use of alcohol and other drugs. In 1976, Congress responded to pressure from drug and alcohol constituency groups with legislation that funded specialized women’s treatment for the first time. Additionally, the National Council on Alcoholism created a special office on women. The programs launched by these initiatives laid the groundwork for beginning to develop an understanding of women’s issues in treatment.

Research slowly emerged that indicated the needs of women struggling with addiction are different than those of men. More importantly, gender-responsive programs demonstrated that women would seek and remain engaged in treatment when it was “holistic” – addressing a broad range of issues from childcare to violence to life-management skills – or tailored specifically to women (Wilsnack & Wilsnack, 1991). Over the next twenty years, proponents of treating substance abuse and dependency in women within a gender-responsive model of care built on these initial findings and developed a body of knowledge that drives the most effective treatment of women today.

To increase engagement and retention and improve outcomes, gender-responsive treatment should integrate evidence-based models and strategies including Motivational Enhancement Therapy and Motivational Interviewing, Cognitive Behavioral Therapy, Motivational Incentives and Trauma-Informed services. Treatment should be culturally sensitive and staff competent and well trained in the areas of gender, race and culture.

How do the Needs of Women Differ?

In addition to the general devastating effects of the disease of addiction, women face issues that are different than those of men. While not all of these issues are unique to women, they are often more common in women or are experienced differently by them. Some of these issues include, but are not limited to:

- Social Stigma
- Physical & Gynecological Health
- Mental Health & Co-Occurring Disorders
- Trauma (including physical and sexual abuse, domestic violence, rape, incest, etc.)
- Relationships
- Parenting & Caregiving
- Needs of Special Populations
- Low Self-Esteem
- Underemployment & Unemployment
- Homelessness

In addition to these issues there are racial and cultural implications. Strategies implemented to address women’s needs should be integrated in the program within a culturally-competent context that includes a set of behaviors, attitudes and policies that come together in an environment to enable working

effectively in cross-cultural situations. Agencies and programs that are culturally competent adapt service delivery practices that are based on an understanding and respect of cultural diversity.

For the LGBT (Lesbian, Gay, Bisexual, Transgender) population, creating an environment that is safe and nurturing of all clients regardless of sexual orientation is particularly critical. Staff in culturally competent agencies recognizes issues of discrimination based on race, culture, sexual orientation, religion, socioeconomic status, education, etc.; and are able to respond in a way that does not continue to oppress or traumatize women.

Based on research, as well as our collective experience in delivering treatment services to women who use, abuse or are dependent on alcohol or other drugs, we are proposing that programs recognized as providers of gender-responsive alcohol and other drug treatment for women address the following issues and needs by incorporating the key programming components offered in this document.

Issues & Approach to Care

This document will focus on some of the gender-related issues that women face, the rationale for addressing such issues in alcohol and other drug treatment settings, an approach for addressing the needs of women related to these issues, and the key components of a gender-responsive system. It should be noted that race and culture play an important role in shaping life experiences. Attention should be paid to understanding differences, and programs providing services to women should reflect this understanding and be sensitive to issues related to race, ethnicity and culture in general.

For the purpose of this document, the following issues will be discussed:

1. Social Stigma
2. Physical & Gynecological Health
3. Co-Occurring Disorders
4. Trauma
5. Relationships
6. Parenting
7. Special Populations

SOCIAL STIGMA

Rationale:

There is greater stigma associated with women who abuse alcohol or other drugs than there is with men (Carter, 1997, 2002a, 2002b; Gomberg, 1996) and this often becomes a barrier to women seeking and staying in treatment. Societal attitudes have played a key role in how women struggling with addiction are viewed, and consequently, treated.

Based on reports from both men and women in treatment, men typically get more support for seeking and entering treatment, while women are often criticized for leaving their families when they enter treatment. Women with substance use disorders are also often perceived as sexually indiscrete and

described as bad mothers. The stigma associated with substance abuse in women is exacerbated among women of color, pregnant women, lesbian women, women with mental and/or physical disabilities, and mothers who abuse substances (U. S. DHHS, 1999; U. S. DHHS, 2000).

Not only do women in treatment face multiple stigmas, they have often experienced gender, racial, cultural and economic discrimination; abuse; violence; homelessness; poverty; and other trauma. These life experiences can diminish a woman's self-worth and consequently determine the types of relationships she chooses and in which she remains involved. Addressing self-esteem and relationships in treatment is critical.

Stigmatizing attitudes and behaviors and other injustices directed toward women with a history of a substance use disorder challenge providers and reinforce the need for expertise if providers are to adequately respond to this client population.

Gender-Responsive Approach:

A gender-responsive program must incorporate activities designed to increase women's knowledge and understanding of societal attitudes and prejudices that have played a role in women's development and will continue to play a role in their recovery. The approach must take into account the toll that negative social stigma plays on an individual's self-esteem and should help women to recognize and build upon their strengths.

Key Components:

The key components of a gender-responsive approach to care related to social stigma include:

1. Education aimed at helping women understand issues related to gender
2. Psycho-educational groups and other activities designed to help raise self-esteem
3. A staff composition of at least 90% female staff
4. A physical environment that reflects women (e.g. artwork, magazines, materials/brochures, etc.)

PHYSICAL & GYNECOLOGICAL HEALTH

Rationale:

Women's health needs differ from those of men, due in large part to genetics, physiology, anatomy and socio-cultural experiences. Reproductive health and other factors across a woman's lifespan require that programs address these needs concurrently with treatment for substance use disorders.

Irrespective of gender, individuals who use or abuse alcohol and other drugs face health risks as a result of not practicing preventive healthcare, neglecting their healthcare needs, increasing their risk of alcohol-related illnesses, and increasing their vulnerability to accidents. Women face even greater

health risks. While women drink less than men, they experience more health problems sooner (Gomberg, 1996). Gender differences in rates of alcohol metabolism mean that women are at risk for alcoholism at far lower levels of daily consumption than men (Frezza, diPadova, Pozzato, et al., 1990). Women become addicted faster (Brady & Randall, 1999). In other words, the progression is quicker in women and occurs after less consumption.

Morbidity and mortality rates are also disproportionately higher for women than for men (U. S. DHHS, 2000) and women suffer from illnesses related to substance use earlier than their male counterparts. For example, the death rates for female alcoholics are 50-100% higher than for men (National Institute on Alcohol Abuse and Alcoholism, 1990). A greater percentage of women die from alcohol-related suicides, circulatory disorders and cirrhosis (Breast and Cervical Cancer Prevention and Treatment Act, 2000; Gomberg, 1996; U. S. DHHS, 2000). According to the Journal of the American Medical Association, women who drink 2-5 drinks a day are 41% more likely to develop breast cancer than non-drinking women (Smith-Warner, Spiegelman, Yaun, et al., 1998). In late stages of alcoholism, women develop hypertension, anemia and malnutrition. The U. S. Department of Health and Human Services, Office of Substance Abuse Prevention (1991), reported that more than 80% of AIDS cases in women are associated with intravenous drug use. The risks associated with HIV/AIDS are even greater among older women, poor women, and women of color (CDC, 2003).

Some of the medical and health consequences of alcohol and other drug abuse in women include, but are not limited to, higher rates of:

- breast cancer
- osteoporosis
- liver disease including alcohol-related cirrhosis
- brain damage
- heart damage
- gastrointestinal problems including pancreatitis
- dementia
- menstrual disorders
- impaired childbearing potential
- HIV/AIDS and other sexually transmitted diseases
- fetal alcohol spectrum disorders (FASD)
- giving birth to a child with developmental and physical conditions including mental retardation and birth defects
- miscarriages

Health education and services need to be available to women across the lifespan and should include services and supports for women who are perinatal, pregnant, postpartum, menopausal and older adults.

Gender-Responsive Approach:

Because of the way in which alcohol and other drugs affect a woman's body, a gender-responsive approach to treating addiction to alcohol and other drugs must include a strong physical health

component. Health issues must be addressed early to help relieve some of the symptoms that may influence relapse. Providers of a women-centered model should establish strong linkages with local hospitals and healthcare professionals, including gynecological and obstetric practices and clinics, that they can rely on to provide healthcare services that reflect knowledge of and sensitivity to women's health issues, and sensitivity to the general health of women. Collaborations with providers of education, support and treatment of HIV/AIDS and other sexually transmitted diseases are also critical.

In addition to acknowledging the many pathways to recovery, treatment providers working with pregnant women in particular need to understand the use of medication-assisted therapies as a viable and sometimes, necessary, strategy for safely detoxifying women from certain substances. Effective collaborations with methadone programs become critical for programs that will offer drug and alcohol treatment to women being maintained on methadone.

Key Components:

The key components of a gender-responsive approach to care related to health include:

1. Priority admission to pregnant women with substance use disorders
2. Education that addresses the physiological effects of alcohol and other drugs on women as compared to men and provides information concerning health risks, medical treatments and healthcare services and resources for women and pregnant women
3. Outreach and education to pregnant women in an effort to prevent prenatal substance exposure including FASD
4. Education about HIV/AIDS and other sexually transmitted diseases and letters of agreement with partners who understand, support, treat and provide education related to HIV/AIDS and STDs
5. Collaborative relationships with appropriate healthcare professionals, hospitals, clinics, etc. with specialties in women's care whenever possible; and the ability to refer women for healthcare services in a timely manner
6. Staff training on pharmacology
7. Staff training on the use of medication-assisted therapies
8. Partnerships with medication-assisted agencies

CO-OCCURRING DISORDERS

Rationale:

Many women who present for addictions treatment have co-occurring disorders. In general, women with substance use disorders are more likely to meet diagnostic criteria for mood disorders, post

traumatic stress and eating disorders, as examples. These, as well as a host of other mental health issues, should be concurrently addressed in women participating in drug and alcohol treatment. Literature suggests that often the onset of psychiatric disorders precedes substance use as women look for ways to self-medicate. Screening and assessment are important so that counselors can identify the need for further mental health assessment based on symptoms and plan effective strategies for treating co-occurring disorders through treatment planning and referral as needed.

Mental illness has been a frequent topic of discussion in the United States for the last three decades. Issues such as de-institutionalization, stigmatization, confidentiality, autonomy of clients, increasing suicide rates, and cultural sensitivity are all associated with mental health treatment (Harris & Licata, 2000; Keigher, 1999; U. S. DHHS, 1999). Other concerns include the chronic aspect of some mental illnesses, the requirement of long-term support, and the co-morbidity of mental illness disorders and substance abuse (The World Health Report, 2001).

Although mental health issues are seen as a high priority of the Department of Health and Human Services (DHHS, 2000), the resulting treatment approaches do not always consider the gender issues of women. Those issues include the high rate of suicide attempts among women (Moscicki, 1994; Lewinsohn, Rohde, Seeley & Baldwin, 2001), the limited levels of social support experienced by many women with a history of substance use disorders (Trulsson & Hedin, 2004), and the large number of poor women with children (U.S. Census Bureau, 2003).

Women and children, for example, represent the majority of the United States population considered poor. Poverty involves the multiple stressors of isolation, uncertainty, frequent negative events, and limited access to helpful resources (NIMH, 2000; U. S. DHHS, 2000), all of which are also correlates of mental health problems in women.

Because clear differences exist in the incidence and presentation of mental illnesses in men and women, diagnosis and treatment of women raises multiple concerns. For example, age, stage in the reproduction cycle, and normal fluctuations in levels of reproductive steroids can mask depressive symptoms in women; psychosocial factors, such as trauma, isolation, and limited economic resources, likely play a role in the etiology of phobias, anxiety, depression, and a variety of mental health problems in women (Young, Campbell & Harper, 2002).

Gender-Responsive Approach:

A gender-responsive program addresses barriers to treatment, including mental health issues. Limited access to mental health services, especially in one's neighborhood (Chandler & McCaul, 2003) and the adverse effects that isolation among women across age groups and symptoms of certain mental illnesses has on treatment compliance (SAMHSA, 1997; Trulsson & Hedin, 2004) are just two examples of barriers. Treatment for co-occurring disorders includes education, prevention and intervention related to FASD and other effects on child development, as they relate to both the client's and children's status.

With the recent development and proposal of Co-Occurring Disorders Competency guidelines and protocols in Pennsylvania, all treatment providers will have the ability to enhance services and increase

the likelihood that clients will receive integrated care. For women, this opportunity is particularly important given their historical positive response to a holistic approach to treatment.

Key Components:

The key components of a gender-responsive approach to treatment for women with co-occurring disorders include:

1. Staff who are cross-trained in substance use and mental illness disorders
2. Competent screening and assessment to identify concurrent mental disorders and assess risk of suicide
3. Integrated Care Plans that address co-occurring disorders in a coordinated manner
4. Collaborations with mental health experts and providers and the availability, either on site or through referral, mental health services across the lifespan
5. Relationships with mental health providers who demonstrate sensitivity to trauma, race, culture, sexual preference, life experiences, age-related issues, and other characteristics of special populations; and who reflect an understanding of the various pathways to recovery
6. Recognition of barriers to mental health treatment, e.g., economic, social, geographic, political
7. Awareness of the impact of systemic factors, e.g., poverty, stigmatization, sexism, on the mental health of women
8. Competency in addressing the special issues of poor women and women of color, e. g., punitive and/or uninformed attitudes of family members and society in general

TRAUMA

Rationale:

Nationally, approximately 85% of women entering treatment for addiction report a history of trauma. The high incidence of women exposed to violence in both childhood and as adults is astounding, with over 55% of all women having experienced some form of trauma in their lifetime (Tjaden & Thoennes, 1998).

In the past, according to Stephanie Covington, “trauma was defined as a specific event—an event you experience, witness, or even hear about happening to someone you love.” She goes on to say that as a treatment field we’ve come to realize that trauma is not only an event, but a particular response. And a woman’s response to trauma may be different from a man’s response.

Approximately 1.8 million women in the United States are abused each year. By age eighteen, one-quarter of girls have been sexually assaulted, compared to one-sixth of boys (Finkelhor, 1992). According to Tjaden and Thoennes (2000), 18% of women have been raped; 8% have been stalked, 22% have been battered by an intimate partner – with over 20% of emergency room visits resulting from domestic violence (Agency for Health Care Policy and Research, 1999).

Women in treatment also report alarming histories of abuse, most commonly related to childhood physical or sexual assault. Seventy percent of women in treatment typically report being abused as children compared to 12% of men. Studies (Najavits, Weiss & Shaw, 1997; Havassy, Wasserman & Boles, 1997) show that 30% - 59% of women in drug treatment programs also suffer from Post Traumatic Stress Disorder (PTSD).

Trauma – physical, sexual and emotional – plays a major and devastating role in the lives of pregnant and parenting women in particular. There is an ever-increasing body of knowledge that shows the direct correlation between early trauma and the increased risk of chemical abuse and dependency in mothers and the legacy of generational abuse (Irwin, 1995; Carter, 2002a; Carter, 2002b).

Violence and related trauma are often reasons that women begin to use alcohol or other drugs in order to self-medicate or numb their feelings (Testa, Livingston & Leonard, 2003). Conversely, substance use and/or abuse can lead to the victimization of women. First, a woman's judgment is impaired when she is under the influence of chemicals. Impaired judgment often results in circumstances that compromise a woman's safety making her a vulnerable target for violence. Second, perpetrators of violence frequently commit crimes of abuse and assault while using alcohol or other drugs. Alcohol has been linked to 75% of rapes and 70% of domestic violence incidents (National Institute on Drug Abuse, 1998).

Gender-responsive programming recognizes the dangers that women face because of gender and acknowledges that the lives of women who enter treatment may have been affected by trauma, including sexual and physical abuse, domestic violence, child pornography, prostitution and other forms of exploitation and violence.

Given this knowledge, any program treating chemically-dependent women must take into account that most women entering their programs will have suffered some form of abuse. The goal of a gender-responsive program related to addressing violence against women should be to provide a safe environment where women can begin to develop an awareness of the connection between addiction and interpersonal violence (Substance Abuse and Mental Health Services Administration, 1997). Staff who work in a gender-responsive program, minimally need to understand the impact of violence on the lives of women, be aware of the implications on the recovery process, be equipped to recognize and screen for trauma and have a relationship with a provider who specializes in treating trauma and abuse. The program must also be able to address how unhealthy and/or unsafe relationships contribute to relapse.

Gender-Responsive Approach:

Because, historically, women have faced higher rates of physical and sexual abuse than men, a gender-responsive approach to the care of recovering women must, minimally, be trauma-informed, and ideally,

trauma-specific. Trauma-informed care includes demonstrating an understanding of trauma and its impact on women. Gender-responsive programs for women that are trauma-specific, integrate trauma services with addictions treatment.

The issue of trauma and violence against women in general should be addressed through all treatment activities from screening and assessment, through individualized treatment planning, resource coordination and discharge planning. Further, the treatment provider should have the ability to offer women a female therapist for individual therapy. Group therapy sessions should be facilitated by female therapists, and when co-facilitated by more than one counselor, at least one should be a woman. All groups should be same-gender. Research has shown that women continue to experience sexual harassment, negative stereotyping and judgment – all of which can lead to the client feeling re-victimized – when placed in treatment programs that serve both men and women together. Additionally, women are less likely to self-disclose in co-ed groups. Studies show that when men and women are together in groups, men seem to share more about their experiences than when they are in all-male groups. Women, on the other hand, are more inhibited and more closed in a mixed group as opposed to an all-female group. Issues like rape, incest, and domestic violence are topics that have proven to be difficult for women to discuss in mixed-gender groups (Carter, 1994).

The literature clearly states that gender-specific and gender-sensitive drug and alcohol treatment are highly effective for women, thereby reducing the risk for repeated patterns of domestic violence (Ramlow, White, Watson & Leukefeld, 1997; Chandler & McCaul, 2003; Brady & Randall, 1999). One of the key components of effective gender-specific treatment is the design of programs that eliminate the barriers to treatment and address the complexity of issues of this target population.

Key Components:

The key components of a gender-responsive approach to care related to trauma include:

1. Knowledge and use of an evidence-based trauma curriculum designed for substance use treatment settings for women
2. Screening and assessment for trauma and trauma-related symptoms
3. Safety planning for women and their children
4. Collaborations with victims-services including rape crisis, sexual assault, domestic violence, and veterans' health agencies
5. Comprehensive staff training program that includes understanding the impact of violence on the lives of women, creating a trauma-responsive environment that includes issues of retraumatization
6. Treatment environment comprised of at least 90% of female staff
7. Opportunity for clients to choose a female therapist who will provide individual treatment

8. Therapy groups that are facilitated by female therapists or, if co-facilitated by two therapists, at least one is a woman

RELATIONSHIPS

Rationale:

Relationships are central in the lives of women. Their relationships with others influence their sense of self, self-esteem decisions, and choices. The Stone Center's Relational Model (Miller, 1976) offers a framework for understanding the psychological development of women, the important role that relationships play in their lives, and the implications for treatment.

The Stone Center model was built on the early work of Jean Baker Miller, who published *Toward a New Psychology of Women* in 1976. Miller proposed that women's psychological development differed significantly from the traditional model of development derived from men's experiences. She postulated that women develop a sense of self and self-worth based on their interactions and relationships with others, and that a woman's primary motivation is to build a sense of connection with others.

The developmental premise supports studies that show relationships are among the biggest motivators for women to seek treatment (Chatham, Hiller, Rowan-Szal, et al., 1999; Grella, 2003; but see Grella & Joshi, 1999). Women, more frequently than men, report relationships and health problems as the two major reasons for entering treatment. Men, on the other hand, identify job and legal problems. Ironically, one of the biggest motivators for women to leave treatment early is also relationships.

Studies indicate that relationships are the most important factors that shape a woman's life and for the majority of women, the most influential relationships are ones they had as children (Miller, 1976). Family relationships establish early patterns for how women relate to men, women, their children, authority figures, peers, and themselves.

Because of the value women place on relationships and the complexity of the various relationships in their lives, treatment providers must be cognizant of how relationships impact recovery. A woman presenting for treatment is likely to have relationships with any or all of the following:

- intimate partner
- child(ren)
- family
- friends
- neighborhood/community
- church
- other health and human services providers
- recovering community, including 12-Step programs
- systems, including legal and child welfare
- people with whom they used drugs
- alcohol and other drugs

Gender-Responsive Approach:

To increase retention, programs treating women must address relationship issues throughout all of their clinical and supportive activities. Additionally, staff should model positive, healthy relationships with co-workers, other colleagues, and the women themselves. Literature documents, for example, that when women with substance use disorders experience uncomfortable relationships with health care providers, they are four times less likely to receive adequate care (Carter, 1996; Cook et. al, 1999), thereby jeopardizing their well-being and the well-being of children for whom women have primary care.

Gender and related issues can be incorporated into every group therapy session. Additionally, the group should be facilitated by, or co-facilitated by at least one woman, who demonstrates the core competencies of woman-centered philosophy. Issues to be addressed include how to identify unhealthy relationships, how to grieve and reconcile loss, effective parenting and nurturing, abusive relationships, and how to create new supportive and mutually satisfying connections.

Counselors should work with women from a strengths-based perspective that acknowledges and honors a woman's abilities. Strengths-based models (Saleeby, 1997) help women to see the considerable power within them. By building on women's strengths as opposed to stripping away their defenses, a therapist has the opportunity to help women create new coping mechanisms without shaming them for past behaviors associated with active addiction. Acknowledging in individual therapy the importance of relationships in women's lives should further help women understand how interactions with others and the messages received from others have shaped their self-concept and affected their self-esteem. Helping a woman to reframe her experiences through cognitive restructuring, for example, can help a woman increase her self-awareness, which will ultimately improve her self-esteem and the choices she makes in recovery.

A gender-responsive approach to treatment addresses relationships throughout programming. Staff understands and models connections, which are relationships that are healthy and supportive. A gender-responsive agency or program that is competent in gender-related issues understands how societal pressures, biases and expectations can affect a woman's self-esteem and, in turn, impact the choices she makes, people whom she chooses to associate with and how she participates in those relationships.

Key Components:

The key components of a gender-responsive approach to care related to relationships:

1. Staff trained in Relational-Cultural Theory – a model that views maturity as growth toward connection and relationship throughout the lifespan
2. Treatment that explores the role of family in a woman's life and offers a family systems approach
3. Treatment that engages extended family and significant others in the treatment process

4. Psycho-educational groups that help women understand the role that relationships have played in their lives – from looking at relationships in concert with the progression of the illness of addiction to the role that relationships will continue to play in their recovery process
5. Psycho-educational groups aimed at building skills related to improving the quality of relationships including communication, assertiveness, stress management, parenting and problem solving

PARENTING

Rationale:

Women are typically their children's primary caregivers and, in cases of single parenthood, women are more frequently the custodial parent than men (Abramovitz, 2000).

With the recent increase in heroin use among young women (Johnston, O'Malley, Bachman & Schulenberg, 2004), more women in their childbearing years are presenting for treatment. This fact poses growing concerns about the potential for an increase in the number of children who will be born to women with substance use disorders. For example, approximately 8,000 children are born annually with FASD (May & Gossage, 2001), although it is entirely preventable and often leads to long-term developmental and physical problems. In addition to human costs, the annual economic cost of services for drug-exposed infants is overwhelming; \$75 million for alcohol, \$500 million for cocaine, and \$1.4 billion for smoking (U.S. DHHS, 2000, p. 16-5).

Substance use disorders have been identified as primary causes of the rise in child abuse and neglect (Child Welfare League of America, 2002). Child protective services experts report that parental substance use and dependency and poverty are among the greatest issues impacting the system (Crosson-Tower, 2004) and that most of the families involved with child-protective service agencies are experiencing problems with alcohol or other drugs. A study conducted more than ten years ago reported that, within the child welfare system, the percentage of children under the age of four who were exposed to drugs in utero was 62% (National Center on Addiction and Substance Abuse).

The reason for the high incidence of child abuse and neglect among women and families struggling with alcohol and other drug problems is that in addition to the general challenges of parenting, women with substance use disorders who are caring for children face multiple and unique issues. The environment in which these mothers and children live is usually unpredictable, unstructured and unstable. Caring for her children can be overwhelming for a mother as she struggles with her own addiction issues. Women also experience gender biases that are rarely encountered by men. For example, mothers with substance use disorders are more at risk of legal interventions in health care settings such as being reported to child protective services and incarceration, than fathers who are addicted (NCASA, 2005). Some issues specifically related to parenting are:

- Abandonment of self and/or of her children
- Trauma experienced as a result of addiction
- Lack of bonding with her children
- Overcompensating or not taking parental role with her children

- Dealing with the cognitive deficits of a child who has been affected as a result of her use
- Losing parental rights of her children (e.g. foster care, adoption, kinship care)
- Shame
- Guilt
- Anger
- Frustration
- Loss of hope
- Criminalization of their drug use more often than males

Conditions including lack of adequate housing, violence, absent or uninvolved fathers, poor or no medical care, poor nutrition, few social or recreational opportunities, lack of family and community supports and isolation all contribute to the disorganization in a child's life and pervasive sense of failure in the mother's life. The disorganization in the child's life can lead to social, emotional, behavioral and physical problems that can affect the child's immediate and long-term development in significant ways (NCASA, 2005; Cook et al., 1999).

Gender-Responsive Approach:

Treatment for women with children is enhanced when their roles as mothers are acknowledged. Gender-responsive treatment integrates parenting skills and nurturing programs that include mother-child bonding experiences, comprehensive parenting education and training, on-site parenting support, therapy groups that address parenting experiences, referrals to outside agencies when needed, and collaborations with systems and organizations such as child-protective service agencies charged with preventing child abuse and neglect.

Additionally, issues related to reunification should be addressed with women whose children are not in their care. Regaining custody or re-establishing their role as the primary caregiver can be a significant motivator for staying in treatment. Gender-responsive care encourages and facilitates ongoing connections with children in foster care or living with relatives and creates opportunities for supervised visits and therapeutic intervention.

Specifically, the goals of a gender-responsive program should be to provide mothers with opportunities to: learn and practice healthy parenting skills; learn effective coping skills; build or re-build a trusting, nurturing relationship with children; increase understanding of child development; build self-esteem and confidence in the role as a mother; address significant parenting issues that are predictors of relapse for her as a recovering woman. Ultimately, addressing parenting issues helps to create a safe and secure environment that will support the healing and healthy development of children whose mothers are recovering from a substance use disorder.

Key Components:

The key components of a gender-responsive approach to care related to parenting include:

1. Access to mother/child programs at all levels of care

2. Availability of childcare, on site or through collaboration, while a mother is receiving treatment
3. Support and assistance to mothers for accessing adequate childcare services and resources once treatment is completed
4. Parenting skills training curriculum that includes: understanding of child development, modeling and teaching age-appropriate responses, teaching limit-setting and effective discipline, improving communication, modeling healthy interaction and play, managing a child's healthcare needs, and providing information on nutrition
5. Opportunities for children who are not with mothers in treatment to interact through frequent and flexible visiting arrangements and planned activities
6. Collaboration with child-protective service agencies and other systems involved in the lives of mothers and their children in an effort to facilitate family reunification whenever appropriate and possible

SPECIAL POPULATIONS

Rationale:

The National Institute of Health has identified critical racial and ethnic disparities in health that result in different outcomes or consequences in some groups. Other factors such as sexual orientation also have been shown to affect health status (Dean et al 2000).

Women's risks for substance use disorders are best understood in the context in which the influences of gender, race, race and ethnicity, culture, health, education, economic status, age, geographic location, sexual orientation and other factors converge. Understanding group differences across segments of the women's population is critical to designing and implementing effective addictions treatment programs for women.

Certain elements of substance use disorders are common to diverse groups of women (e.g., trauma, socioeconomic factors). Each group has unique features that influence their engagement and successful completion of treatment including cultural values and beliefs about health issues.

Healthy sexuality is integral to one's sense of self-worth. Sexuality represents the integration of biological, emotional, social and spiritual aspects of who one is and how one relates to others. If healthy sexuality is defined as the integration of all these aspects, it is easy to understand why substance use and addiction can have an impact on every area of a woman's sexuality (Covington 2008a, 1999a, 2007). Many women begin to explore their sexuality, body image and sexual identity while transitioning into recovery. The LGBT population presents unique challenges in treatment so counselors may need to help a woman determine her sexual identity as a heterosexual, lesbian or bisexual person.

In addition to race, culture and sexual orientation; women with HIV and AIDS, physical and cognitive disabilities, involved in the criminal justice system and who are homeless all present challenges that require sensitivity, competence and collaboration with experts identified in the community to serve these special populations.

Gender Responsive Approach:

For detailed information on substance related disorders across racially and ethnically diverse populations; the influence of culture on substance use patterns, help-seeking behavior, and health beliefs; and guidelines for culturally congruent and competent treatment services, see the planned TIP Improving Cultural Competence in Substance Abuse Treatment (Center for Substance Abuse Treatment (CSAT) in development. See also TIP Addressing the Specific Needs of Women. Suggestions are offered for culturally congruent clinical, programmatic and administrative strategies across all special populations across four domains: demographics, substance abuse patterns, clinical treatment issues, and resiliency factors. Groups listed include racially and ethnically diverse women, LGBT individuals, women in later life, women in rural communities and other special populations.

Key Components:

The key components of a gender-responsive approach to care related to special populations include:

1. Culturally diverse staff
2. Culturally sensitive and competent screening and assessments
3. Physical environment that reflects inclusiveness and appreciation for differences; congruence between women-centered culturally competent philosophy of care and physical attributes of treatment setting
4. Linkages and collaborations with community-based organizations that are culturally competent, gender-sensitive and trauma-informed
5. Cross training with collaborative partners
6. HIV/AIDS education, prevention and intervention services
7. Outreach and positive relationships with the criminal justice system and law enforcement
8. Comprehensive training on cultural diversity and competency

Support Services

In addition to addressing the gender-related issues discussed in this document, programs designed for women should also deliver on site, or through partnerships and collaborations, support services that reflect women's lives. Support services, like life skills development classes that include topics such as parenting, budgeting, job seeking, relapse prevention and health enhance treatment services, offer women an array of information and resources designed to help them make a healthy transition from treatment to community. Some of the support services offered either directly or through referral that enhance women's treatment experiences include:

- Case Management/Resource Coordination
- Employment Training and Referral
- Childcare
- Children’s Programming

While all of these are important, for the purposes of this paper, only case management will be further discussed.

Case Management/Resource Coordination

One of the most important support services necessary to enhance women’s treatment experiences and improve outcomes is case management. Case management or coordination of the various resources and services required to holistically address the treatment needs of women can be provided on site or through partnerships with community-based organizations.

Case management requires establishing and negotiating relationships with community providers on behalf of clients and facilitating communication between a woman and those external resources. The functions that comprise case management are assessment and identification of needs, planning, linkage, monitoring, and advocacy. The resources an individual seeks may be external in nature (e.g., housing and education) or internal (identifying and developing skills).

The role of a case manager is that of teacher, advocate, recovery coach and mentor. While therapeutic treatment focuses on helping a woman establish a foundation in recovery and maintain long-term success, case management complements and supports her goals by empowering her to manage her life in the community and with natural supports. As women are relational, an effective case manager will work collaboratively with the client, involving her in the process, rather than dictating what she should do and how she should do it.

Rationale:

While both men and women recovering from substance use disorders require case management services, women, and in particular pregnant and parenting women, require approaches based on their life experiences. Men and women both suffer physically, economically, legally, and socially as a result of their untreated addiction. Women, however, must be viewed within a social context that takes into account physiology, caretaking responsibilities, relational dependency, disparate earning potential and trauma.

Gender-Responsive Approach:

Assessment – A thorough assessment should be conducted collaboratively with a woman, using a strengths-based approach. Helping women identify their needs while in and beyond treatment lays the foundation for service planning.

Planning – Planning consists of coordinating a set of health, human and support services that is individualized to meet a particular client’s needs. Integrated Care Plans developed with the client based

on the results of the assessment are critical to effective resource coordination. Like the assessment, planning should be driven by the client, and be framed to build on her strengths.

Linkage – Service linkage involves the process of ensuring that clients are provided the services they need in a coordinated, effective, and efficient manner. Developing mutually supportive collaborations based on an understanding of the population being served helps to facilitate the referral process and resource coordination. As a case manager creates and negotiates relationships with other providers on behalf of the client, the case manager models how to access and navigate needed community services.

Monitoring – Tracking the effectiveness of outside resources and services, and providing support to a client helps to continue to engage women in their own recovery process.

Advocacy – Case managers often advocate on behalf of clients with many systems, including agencies, families, legal systems, and legislative bodies. Client advocacy should always be geared toward achieving the goals established in the service plan. At times, intervening on behalf of clients is necessary to ensure a woman’s needs are being addressed and continues to model assertiveness and problem solving.

Key Components:

1. Collaborations and linkages with organizations that are culturally sensitive
2. Referral agreements that address confidentiality and privacy
3. Involve partners and family members as appropriate to enhance women’s recovery
4. Recognition of the reality of women’s lives and responsibilities
5. Empowerment strategies designed to help women take control of their own treatment
6. Work toward eliminating barriers, as identified by clients, including but not limited to childcare, transportation, housing, poverty, legal involvement, lack of social support and mental health issues

Staff Development & Training

Recruitment, hiring and training policies and practices are critical to providing quality care that is effective in treating substance use disorders. A qualified staff with excellent skills and relevant experience will have the confidence to deliver treatment and support services that reflect the lives of women.

On-going staff development opportunities and agency training requirements should address gender-specific issues. Agencies or programs that are gender-responsive for women should develop and implement annual training plans that are designed to increase the staff’s knowledge and understanding of women-specific issues. Training plans should include a significant number of training hours related to

gender-specific issues, most of which are addressed in this document. Specific staff training and professional development topics should include, but not be limited to:

- The impact of trauma on the lives of women
- Trauma-informed and trauma-specific programming for women with substance use disorders
- Parenting skills training/retraining
- Reproductive and physical health issues impacting women
- Methadone/Narcotic Treatment and Pregnant Women
- Co-occurring disorders
- Relational model

In Summary

Addiction to alcohol and other drugs is an illness that has far-reaching effects. When left untreated, substance use disorders devastate individuals, families and communities. And, like many other illnesses, there is hope because treatment is available. For women, that treatment must reflect their lives and pay particular attention to those issues that are unique to them, or experienced differently by them as a group than by men.

Organizations and programs that offer gender-responsive treatment and support services to women suffering from substance use disorders are more than sensitive to the issues that women face as they strive for recovery; they are informed and experienced in translating that knowledge into a specific course of treatment that clearly addresses women's needs.

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