

**Substance Abuse Treatment: Addressing the Specific Needs of omen**

**A Treatment Improvement**

**Protocol**

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# A Treatment Improvement Protocol

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Public Health Service

Substance Abuse and Mental Health Services Administration

1. Choke Cherry Road Rockville, MD 20857

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### What Is a TIP?

Treatment Improvement Protocols (TIPs) are developed by the Center for Substance Abuse Treatment (CSAT), part of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S.

Department of Health and Human Services **(HHS).** Each TIP involves the development of topic-specific best-practice guidelines for the prevention and treatment of substance use and mental disorders. TIPs draw on the experience and knowledge of clinical, research, and administrative experts of various forms of treatment and prevention. TIPs are distributed to facilities and individuals across the country. Published TIPs can be accessed via the Internet at [http://store.samhsa.gov.](http://store.samhsa.gov/)

Although each consensus-based TIP strives to include an evidence base for the practices it recommends, SAMHSA recognizes that behavioral health is continually evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. If research supports a particular approach, citations are provided.

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# Forevvord

The Treatment Improvement Protocol (TIP) series fulfills the Sub­ stance Abuse and Mental Health Services Administration's (SAM­ HSA's) mission to improve prevention and treatment of substance use and mental disorders by providing best practices guidance to clinicians, program administrators, and payers. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation re­ quirements. A panel of non-Federal clinical researchers, clinicians,

program administrators, and patient advocates debates and discusses their particular area of expertise until they reach a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIPs panelists and re­ viewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practic­ ing clinicians and administrators to serve, in the most scientifically sound and effective ways, people in need of behavioral health ser­ vices. We are grateful to all who have joined with us to contribute to advances in the behavioral health field.

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Foreword **xv**

### Executive Summary

Clinicians and program administrators are increasingly aware of the important differences between men and women with regard to the physical effects of substance use and the specific issues related to substance use disorders. They are also recognizing that these differences have an impact on treatment-that gender does make a difference. When women's specific needs are addressed from the

outset, improved treatment engagement, retention, and outcomes are the result.

This TIP endorses a biopsychosociocultural framework based on clinical practice and research centered on women. By placing emphasis on the importance of context, many topics examine the

role of factors that influence women's substance use from initiation of use to engagement of continuing care treatment services, i.e., relationships, gender socialization, and culture. The knowledge and

models presented here are grounded in women's experiences, built on women's strengths, and based on best, promising, or research-based practices. The primary goal of this TIP is to assist substance abuse treatment providers in offering effective, up-to-date treatment to adult women with substance use disorders.

The TIP is organized into eight chapters. The following section summarizes the content of each chapter to present an overview of this publication.

##### Creating the Context

The consensus panel for this TIP proposes that substance abuse treatment for women be approached from a perspective that encompasses the contexts of women's lives. These contexts include a woman's social and economic environment; her relationships with family, extended family, and support systems; and the impact of gender and culture. As a framework to explore women's substance

use disorders, treatment needs, and treatment approaches, this TIP adopted two systemic models: Bronfenbrenner's ecological model and CSAT's *Comprehensive Substance Abuse Treatment Model for Women and Their Children.* Both models endorse the relevance

and influence of multisystems and their bidirectional influence upon women's lives.

What makes gender an important clinical issue in substance abuse treatment? Are there gender differences in the development and pattern of substance use disorders? Do these differences warrant specific treatment approaches? To date, there is considerable evidence denoting that gender differences do exist, and these differences begin with early risk factors for substance use and extend throughout the course of treatment and recovery. Grounded

in research, this TIP begins with unique biopsychosocial and developmental issues of women that create or intensify gender differences across the continuum of care.

Knowledge of these unique factors is essential for treatment providers to fully understand the contexts of women's lives and their needs.

Based on the premise and knowledge that women are biopsychosocially unique in ways that are relevant to substance use, substance use disorders, and substance abuse treatment, this consensus panel endorses core principles for gender responsive treatment for women, such

as-

* Acknowledging the importance as well as the role of the socioeconomic issues **and** differences among women.
* Promoting cultural competence specific to

**won1en.**

* Recognizing the role as well as the significance of relationships in women's lives.
* Addressing women's unique health concerns.
* Endorsing a developmental perspective.
* Attending to the relevance and influence of various caregiver roles that women often assume throughout the course of their lives.
* Recognizing that ascribed roles and gender expectations across cultures affect

societal attitudes toward women who abuse substances.

* Adopting a trauma-informed perspective.
* Using a strengths-based model for women's treatment.
* Incorporating an integrated and multidisciplinary approach to women's treatment.
* Maintaining a gender responsive treatment environment across settings.
* Supporting the development of gender competency specific to women's issues.

##### Patterns of Use: From Initiation to Treatment

Numerous factors influence the reasons for initiation of substance use among women, and a number of these factors are more prevalent among women than men. Women often report that stress, negative affect, and relationships precipitate **initial** use. In fact, women are often introduced to substance use by a significant

relationship such as boyfriend, family member, or close friend. Though genetics also may be a significant risk factor for women, more research supports familial influence-a combination of genetic and environment effects. Less is known about familial influence of illicit drugs, but parental alcohol use increases the prevalence of alcohol use disorders among women by at least 50 percent. Family of origin characteristics play a role too. Exposure to chaotic, argumentative, and violent households, or being expected to take on adult responsibilities as a child, are other factors associated with initiation and prevalence of substance use disorders among the female population.

Women are significantly influenced by relationships, relationship status, and the effects of a partner's substance abuse. Women dependent on substances are more likely to have partners who have substance use disorders.

**At** times, women perceive shared drug use with their partner as a means of connection or of maintaining the relationship. Often, rituals surrounding drug use are initiated by a male partner, and women bear more risk in

contracting HIV/AIDS and hepatitis by sharing needles or having sexual relationships with men who inject drugs. Relationship status similarly influences use and potential development of substance use disorders. Marriage appears protective, whereas separated, never married, or divorced women are at greater risk for use and the development of substance use disorders.

Relationship influence does not stop at the point of treatment entry; relationships also

significantly influence treatment engagement, retention, and outcome among women.

Other risk factors associated with initiation of use and the prevalence of substance use

disorders include sensation-seeking, symptoms of depression and anxiety, posttraumatic stress and eating disorders, and difficulty in regulating affect. Women with a history of trauma, including interpersonal and childhood sexual abuse, are highly represented in substance abuse samples. In addition, sociocultural issues play a significant role across the continuum beginning with enhanced risk for substance use. Degree

of acculturation, experiences of discrimination, and socioeconomic status are prominent risk factors from the outset but continue to influence women's substance use, health status, treatment access, and help-seeking behavior.

Among women, six patterns of substance use clearly emerge from empirical data. First, the gender gap is narrowing for substance use across ethnicities, particularly among young women. Second, women are more likely to be

introduced to and initiate substance use through significant relationships, while marital status appears to play a protective role. Third, women accelerate to injecting drugs at a faster rate than men, and rituals and high-risk behaviors surrounding drug injection are directly influenced by significant relationships. Fourth, women's earlier patterns of use (including age of

initiation, amount, and frequency) are positively associated with higher risks for dependency.

Next, women are more likely to temporarily alter their pattern of use in response to caregiver responsibilities. And last, women progress faster from initiation of use to the development of substance-related adverse consequences.

Substance use is not as prevalent among women as it is among men, but women are as likely as men to develop substance use disorders after initiation. Women who are pregnant are likely to reduce or remain abstinent during pregnancy; however, continued use is associated with a wide range of issues and effects-from less prenatal care to potential irreparable harm to the child from fetal exposure. Among those entering treat­ ment, women are more likely to report drug use as the main reason for admission.

Physiological Effects of Alcohol, Drugs, and Tobacco on Women

Women develop substance use disorders **in**

less time than men. Some factors that either influence or compound the physiological effects of drugs and alcohol include ethnicity, health disparity, socioeconomic status, developmental issues, aging, and co-occurring conditions.

Although research on the physiological effects of alcohol and illicit drugs on women is limited and often inconclusive, significant differences have been found in the way women and men metabolize alcohol. Women have more complications and more severe problems from alcohol use than do men, and these complications and problems develop more rapidly. This phenomenon is known as "telescoping." Complications include liver

disease and other organ damage; cardiac-related conditions such as hypertension; reproductive consequences; osteoporosis; cognitive and other neurological effects; breast and other cancers; and greater susceptibility and progression of infections and infectious diseases, including HIV/AIDS and hepatitis C virus (HCV).

Although many physiological effects of licit and illicit drugs have not been well studied, research has shown that abuse of substances such as stimulants, opioids, and some prescription (e.g., anxiolytics, narcotic analgesics) and

over-the-counter (e.g., laxatives, diuretics, diet pills) drugs causes adverse effects on women's menstrual cycles and gastrointestinal, neuromuscular, and cardiac systems, among others. With regard to nicotine use, women who smoke increase their risk of lung cancer. Currently, cancer is the second leading cause of death among women, with mortality rates higher for lung cancer than breast cancer.

Other physiological consequences of tobacco use include, but are not limited to, increased

risks for peptic ulcers, Crohn's disease, estrogen deficiencies, strokes, and atherosclerosis.

Women who smoke are more likely to have chronic obstructive pulmonary disease and coronary heart disease.

Women who use alcohol, drugs, or tobacco while pregnant or nursing expose their fetuses

or infants to these substances as well. The most thoroughly examined effect of alcohol on **birth** outcomes is fetal alcohol syndrome, which involves growth retardation, central nervous system and neurodevelopmental abnormalities, and craniofacial abnormalities. Alcohol and drug use by pregnant women is associated with many complications, including spontaneous abortion, prematurity, low birth weight, premature separation of the placenta from the uterine wall, neonatal abstinence syndrome, and fetal abnormalities. Likewise, women who are pregnant and use tobacco are more likely to deliver premature and low birth weight infants.

###### Screening and Assessment

Understanding the extent and nature of

a woman's substance use disorder and its interaction with other areas of her life is essential for accurate diagnosis and successful treatment. This understanding can be acquired through screening and assessment. Screening is typically a brief process for identifying whether certain conditions may exist and usually involves a limited set of questions to establish whether

a more thorough evaluation and referral(s) are needed. Sociocultural factors-ethnicity, culture, acculturation level, language, and socioeconomic status-are particularly relevant in screening and assessment selection, in determining the appropriateness of the

instruments, and in interpreting the subsequent results. Sociocultural and socioeconomic characteristics of the client can affect testing expectations and behavior of both the counselor and client during the screening and

assessment process; e.g., the client's distrust and subsequent reluctance in the testing process or the counselor's expectation that a woman with lower socioeconomic status will have a positive screening for alcohol or drug use.

For women, general alcohol and drug screening that determines current or at-risk status for drug and alcohol use during pregnancy is essential. However, healthcare professionals sometimes overlook the necessity of drug

and alcohol screening for older, Asian, and/

or middle- and upper-class women who are pregnant. Screening is more likely based on preconceived beliefs concerning greater

prevalence of substance abuse among women from diverse ethnic groups. Counselors and intake personnel may also alter their behavior when working with diverse populations, such as eye contact, body language, and communication styles, that ultimately affect clients' responses and trust in the screening process.

Other screenings involve the determination of co-occurring risks, conditions, or disorders, including general mental disorders, mood

and anxiety disorders, risk of harm to self or others, history of childhood trauma and

interpersonal violence, and eating disorders. Considering women's likely involvement with health care providers, screening for substance use and abuse should be a standard practice. Yet, the implementation of screening, regardless of setting, is only as good as the protocol in providing feedback, referral, and follow-

up. Screening is not an intervention. What makes the difference is how a woman's positive endorsement of screening questions leads to feedback, referral, further assessment, and intervention, if warranted.

The difference between screening and assessment is **that** assessment examines several domains in a client's life in detail so that diagnoses can be made for substance use disorders and possible co-occurring mental disorders. Assessment is an ongoing process in which the counselor forms an increasingly clearer picture of the client's issues, how they can best be addressed, and how the client is changing over time. An assessment interview, such as a structured psychosocial interview, an unstructured psychosocial and cultural history, and/or the Addiction Severity Index, needs sufficient time to complete. The degree to which it is possible or advisable to probe in

depth in different areas of functioning depends on the individual issues, the needs of the woman, the complexity of her issues, and the level

of rapport between the client and clinician. Equally important, assessment processes should explore coping styles, strengths, and available support systems. An assessment process would

not be complete without a health assessment and medical examination.

In sum, screening and assessment for women must be approached from a perspective that allows for and affirms cultural relevance and strengths. Whenever possible, instruments that have norms established for specific population groups should be used. Counselors' sensitivity to the clients' cultural values and beliefs, language, acculturation level, literacy level, and emotional ability to respond facilitates the assessment process and helps women engage in treatment.

##### Treatment Engagement, Placement, and Planning

Women face many obstacles and challenges **in** engaging in treatment services: lack of collaboration among social service systems, limited options for women who are pregnant, lack of culturally congruent programming, few resources for women with children, fear of loss of child custody, and the stigma of

substance abuse. On one hand, intake personnel and counselors can help women tackle and overcome personal barriers to treatment (such as issues of motivation and shame); yet, on the other hand, programming and administrative policies must address obstacles surrounding program structure, interagency coordination, and service delivery to improve treatment engagement. In recent years, more effective engagement strategies have been implemented. Outreach services, pretreatment intervention groups, and comprehensive and coordinated case management can effectively address the numerous barriers and the array of complex problems that women often express in their role as caregivers.

Treatment placement decisions are based not only on the woman's individual needs and

the severity of her substance use disorder but also on the treatment options available in the community, her financial circumstances, and available healthcare coverage. To determine treatment placement, the American Society of Addiction Medicine's Patient Placement

Criteria, Second Edition Revised (ASAM's PPC-

2R), are used widely, and the levels determined by these criteria are useful to standardize treatment placement. To date, empirical literature supporting specific placement criteria for women is limited. The treatment levels suggested by the consensus panel and supported by ASAM criteria include pretreatment or

early intervention; detoxification; outpatient treatment; intensive outpatient treatment (IOT); residential and inpatient treatment; and medically managed, intensive inpatient

treatment. Specific placement criteria must also account for pregnancy, child placement, and children services. Treatment services for women must extend beyond standard care to address specific needs for women, pregnant women, and women with children such as medical services, health promotion, life skills, family- and child­ related treatment services, comprehensive and coordinated case management, and mental health services.

When clients participate fully in decisions related to treatment, they are more likely to understand the process and develop realistic expectations of treatment. Active involvement of clients in all aspects of treatment planning and placement significantly contributes to both recovery and empowerment and is essential to

the development of meaningful, effective services for women.

##### Substance Abuse Among Specific Population Groups and Settings

Women who are of different racial and ethnic groups, different sexual orientations, in the criminal justice system, living in rural areas, older, and who speak languages other than English are among the population groups that mayexperience unique challenges that affect their substance use or abuse and its treatment.

The risk for substance abuse and its consequences and optimal processes for treatment and recovery differ by gender, race, ethnicity, sexual orientation, and other factors. The complex interplay of culture and

health-as well as the influence of differing attitudes toward, definitions of, and beliefs about health and substance use among cultural groups-affects the psychosocial development of women and their alcohol, drug, and tobacco use and abuse. Women's risks for substance abuse are understood best in the social and historical context in which the influences of gender, race and ethnicity, education, economic status, age, geographic location, sexual orientation, and other factors converge. Understanding group differences across segments of the population of women is critical to designing and implementing effective substance abuse treatment programs for women.

Training helps staff members recognize the individual and group strengths and resiliency factors that can assist women from diverse identity groups in recovery. These include beliefs regarding health care and substance abuse; the value the individual or identity group places on family and spirituality; the effects of group history on current behaviors; how women are socialized in a particular culture; and the flexibility of gender norms, communication styles, rituals, the status of women, the stigma the group or individual faces, and attitudes toward self-disclosure and help-seeking behavior.

##### Substance Abuse Treatment for Women

Gender does not appear to predict retention in substance abuse treatment. Women are

as likely as men to stay **in** treatment once treatment is initiated. Factors that encourage a woman to stay in treatment include supportive therapy, a collaborative therapeutic alliance, onsite child care and children services, and other integrated and comprehensive treatment services. Sociodemographics also play a role

in treatment retention. Studies suggest that support and participation of significant others, being older, and having at least a high school education are important factors that improve retention. Criminal justice system or child protective service involvement also is associated

with longer lengths of treatment. Women are more likely to stay in treatment if they have had prior successful experiences in other life areas and possess confidence in the treatment process and outcome. Although pregnancy may motivate women in initiating treatment, studies suggest that pregnant women do not stay in treatment as long and that retention may be significantly affected by stage of pregnancy and the presence of co-occurring psychiatric disorders.

Limited research is available highlighting specific therapeutic approaches for women outside of trauma-informed services. In recent years, more attention has been given to effective women's treatment programming across systems with considerable emphasis on integrated care and the identification of specific treatment issues and needs for women. Gender specific factors that influence the treatment process

and recovery evolve around the importance of relationships, the influence of family, the role of substance use in sexuality, the prevalence and history of trauma and violence, and common patterns of co-occurring disorders. Among women with substance use and co-occurring mental disorders, diagnoses of posttraumatic stress and other anxiety disorders, postpartum depression and other mood disorders, and eating disorders are more prevalent than among men who are in treatment for substance use disorders. Consequently, clinical strategies, treatment programming, and administrative treatment policies must address these issues to adequately treat women. Likewise, women often need clinical and treatment services tailored

to effectively address pregnancy, child care, children services, and parenting skills.

##### Recovery Management and Administrative Considerations

Empirical data suggest that women are as likely as men to attend continuing care services.

Transition from a more intensive level of care to less intensive services has proven to be challenging for all clients, but evidence suggests that women will continue with services if they

stay within the same agency and/or effort is made to connect them to the new service provider prior to transition.

Gender does not consistently predict treatment outcome. For example, women have comparable abstinent rates with men and are as likely to complete treatment. Even so, women are more likely to have positive treatment outcomes in the following ways: less incarceration, higher rates of employment, and more established recovery­ oriented social support systems. Women and men do not differ in relapse rates. It is more likely that individual characteristics hold the key in determining who may be a greater risk for relapse. However, there is a delineation

of the types of risks and triggers that make women versus men more vulnerable to relapse, and women exhibit different emotional and behavioral responses during and after relapse. Women report more interpersonal problems and strong negative affect, including symptoms of depression, severe traumatic stress reactions to early childhood trauma, and low self-worth, as precipitants of relapse. They also display a lack of coping skills, greater difficulty in severing their connections with individuals who use, and a failure in establishing new recovery-oriented friends. Conversely, women who relapse are more likely to seek help and have shorter relapse episodes.

Other considerations in providing treatment to women involve programmatic and administrative issues. First, full participation

of clients as partners in treatment is important, and both the program and client will benefit

if they are involved in program development and serve in an advisory capacity. Programs will likely improve the quality of services and clients will benefit from an increase in self­ efficacy, the attainment of specific skills, and a reduced stigma from substance abuse treatment.

Gender-responsive treatment involves a safe and non-punitive atmosphere, where staff hold a hopeful and positive attitude toward women and show investment in learning about women's experiences, treatment needs, and appropriate interventions. Administrators need to invest

in staff training and supervision and show a commitment to training beyond immediate services. Training should include other social and healthcare facilities and personnel within the community to enhance awareness, identify women with substance use disorders, and increase appropriate referrals. As research, programming, and clinical experience expand along gender lines in substance abuse treatment, clinicians and administrators alike will have considerable opportunities in adapting new standards of care for women.

# 1 Creating the Context

##### Overview

**In This Chapter**

Creating the Context

Gender Responsive Treatment Principles

Women's Biopsychosocial Uniqueness

Organization of this **TIP**

Women with substance use disorders have unique biopsychosocial needs that should be addressed if their treatment is to be successful. This TIP examines the current state of women's substance abuse treatment needs, approaches, and experience; highlights promising strategies and best practices for treatment counselors working with female clients; and explores evidence-based research and clinical issues that affect treatment for women. The primary goals of this TIP are to help substance abuse treatment counselors and administrators provide effective treatment for women and to assist clinicians in equipping their female clients with the tools they need to maintain recovery.

Following is an introduction to many of the themes and issues discussed in greater depth in later chapters. This chapter presents a guiding framework for treatment of women who have substance use disorders. It highlights the multiple contexts of women's lives and treatment issues, provides gender responsive principles of treatment, and presents the unique biopsychosocial needs that characterize

the issues women face in treatment. The chapter concludes with a discussion on guidelines for readers and definitions of terms and concepts used in this TIP.

##### Creating the Context

According to the Substance Almse and Mental Health Services Administration's (SAMHSA's) National Survey on Drug Use and Health (NSDUH), 6.2 percent of females ages 12 and older were classified with substance dependence or abuse in 2004, but only

0.9 percent offemales received treatment in 2004 (SAMHSA 2005).

Creating the Context

The medical, social, emotional, and financial consequences and costs of these disorders to women's families and society are enormous.

By and large, women with substance use disorders must find a way to support themselves and their children, often with little experience or education and few job skills. They frequently have to overcome feelings of guilt and shame

for how they treated their children while abusing substances. When a woman becomes pregnant, her motivation to seek treatment may rise greatly. However, pregnancy itself can be a barrier to treatment because substance abuse treatment programs are not always able to admit pregnant women or to provide the services required, such as medically indicated bed rest, transportation to prenatal care, and nutritious meals (Jessup et al. 2003). Some women fear the negative consequences that will result if their substance abuse becomes known.

In many States, pregnant and parenting women can be reported to child protective services, lose custody of their children, or be prosecuted for using drugs. On top of additional healthcare needs, substance use during pregnancy confers stigma and shame, which may create another challenge in treatment.

A high proportion of women with substance use disorders have histories of trauma, often perpetrated by persons they both knew and trusted. A woman might have experienced sexual or physical abuse or witnessed violence as a child. She may be experiencing domestic violence such as battering by a partner or rape as an adult (Finkelstein 1994; Young and

Gardner 1997). These traumas contribute to the treatment needs for women.

The societal stigma toward women who abuse substances tends to be greater than that toward men, and this stigma can prevent women from seeking or admitting they need help. Women who use alcohol **and illicit** drugs often have great feelings of shame and guilt, have low levels of self-esteem and self-efficacy, and often are devalued or disliked by other women. These feelings make it difficult for women to seek

help or feel that they deserve to be helped­ creating yet more treatment needs that must be addressed. Gender role expectations in many

cultures result in further stigmatization of substance use; additional challenges face women who are of color, disabled, lesbians, older, and poor.

Over the last decade, women with substance use disorders have increasingly been the subject of scientific study. Studies have explored the effects of alcohol and illicit drugs on pregnancy in greater detail, best practices in substance abuse treatment for women, the impact of trauma

and the need for trauma-informed services, and the importance of incorporating a gender responsive framework. More recently, research is burgeoning in the area of outcome variables, relapse prevention, women and child services, and specific treatment approaches. This TIP seeks to help the substance abuse treatment system lower barriers, improve treatment, and

assist clinicians in providing their female clients with the tools needed to maintain recovery.

Improved collaboration within the current system of health care and social services will result in more comprehensive and responsive care for women in recovery.

Sociocultural Context

The consensus panel for this TIP approached substance abuse treatment for women from

a perspective that encompasses the multiple contexts of women's lives. This TIP provides a systemic framework for looking at women with substance use disorders, and uses Bronfenbrenner's ecological model (1989), where women are engaged **in** multisystems and relationships that maintain a bidirectional influence-the systems and relationships influence the woman with a substance use disorder and the woman, along with the impact of her substance use, influences her

relationships and the systems that interact with her. Figure 1-1 depicts a woman as the center of a circle, surrounded by other concentric rings.

Each ring represents a different system with the closest adjacent ring representing her most immediate relationships-the microsystem.

The following ring, the mesosystem, represents the interrelationships between her immediate relationships and systems; e.g. the interaction

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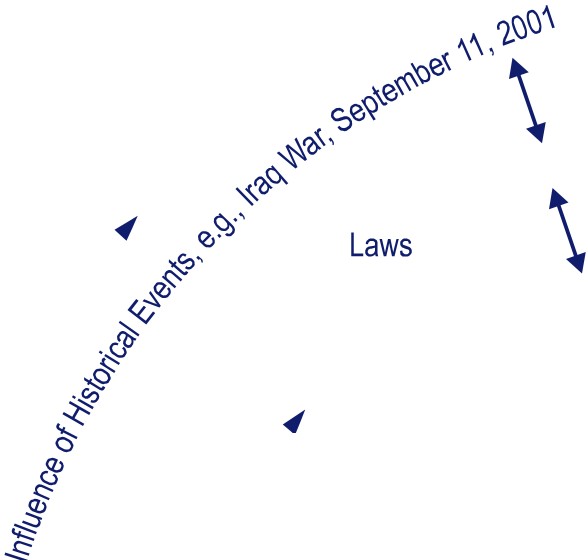
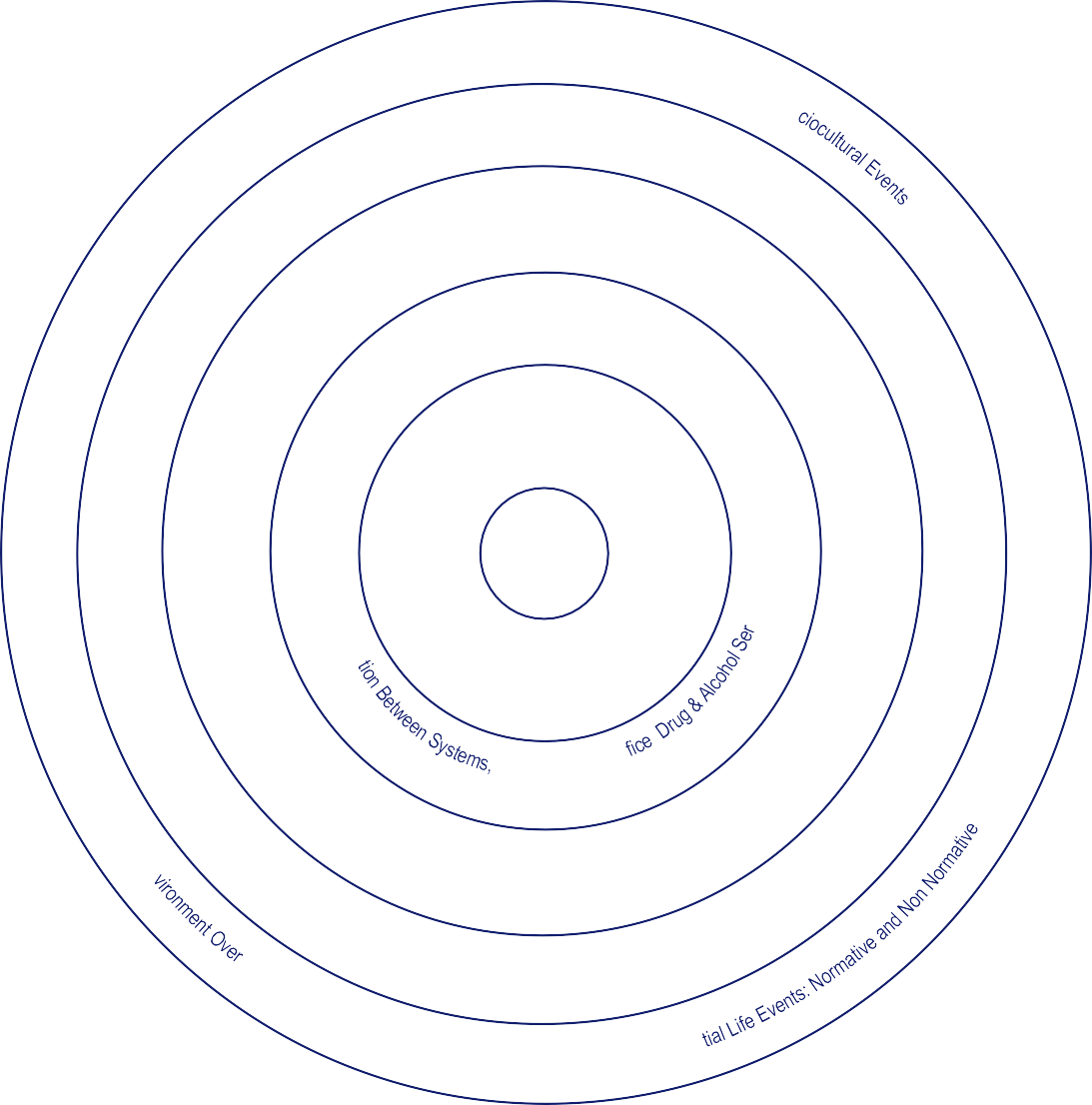
between her family and school, the potential influence or conflict between her substance using peer group and her family. Next, the exosystem represents larger systems that directly influence the woman but where the woman has no direct active role; e.g., county funding for treatment or State and Federal laws pertaining to sentencing or child protective services. The macrosystem

is the largest system that involves cultural values and beliefs, gender socialization, political ideologies, etc. Each system is influenced by chronology, or life events. These events, either

normative or non-normative individual events at specific developmental periods or historical

events, can have significant impact and influence on further development, treatment needs and recovery, and ultimately interactions among all systems.

Using a systems approach is appropriate regardless of gender, yet it is a vital framework for understanding women's treatment needs and the impact of substance use on their relationships and caregiving roles. Consistent



***Figure 1-1***

***A Woman's life in* Context**

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Source: Bronfenbrenner 1989

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with Bronfenbrenner's model, this TIP uses SAMHSA's Center for Substance Abuse Treatment's (CSAT's) *Comprehensive Substance Abuse Treatment Model for Women and*

*Their Children* as the keystone in addressing women's treatment needs and services. Figure 1-2 highlights the four broad interrelated elements of CSAT's comprehensive model of care including clinical treatment services, clinical support services, community support services, and cultural competence. For more

in-depth information about this model, refer to Appendix B. This model is an update of a model published in 1994 in *Practical Approaches in the Treatment of Women Who Abuse Alcohol and Other Drugs* (CSAT 1994a).

###### Gender Responsive Treatment Principles

The principles articulated by the consensus panel, which serve as the TIP's conceptual framework, are explained below. Each principle is derived from research that highlights the distinctive characteristics and biopsychosocial issues associated with women in general and specific to women with substance use disorders.

* **Acknowledge the importance and role** of socioeconomic issues and differences **aniong w01uen.** Biological, cognitive­ behavioral, and psychological dimensions

of women's substance use and abuse should be framed in their socioeconomic contexts



***Figure 1-2 Interrelated Elements in the Comprehensive Treatment Model***

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including, but not limited to, employment, educational status, transportation, housing, literacy levels, and income.

* + **Promote cultural competence** specific **to w0111en.** Treatment professionals and staff must understand the worldviews and

experiences of women from different ethnic and cultural backgrounds, as well as the interaction among gender, culture, and substance use to provide effective substance abuse treatment. In addition, effective treatment will depend equally on attention and sensitivity to the vast diversity among the female population, including overlapping identities of race, class, sexual orientation,

age, national origin, marital status, disability, and religion.

* + **Recognize the role and significance of relationships in women's lives.** The

relational model recognizes the centrality of relationships or connections in women's lives and the importance of those relationships with respect to alcohol, tobacco, and drug use. While substance use may initially play an integral role in making or maintaining connections in relationships, the relational approach views the development of substance use disorders as a "disconnection" and stresses the development and repair of connections to others, oneself, one's beliefs, and one's culture as critical for recovery.

The relational model takes a family-focused perspective, using a broad definition of family as those individuals a woman views as her significant support system. In this model, a woman's children are included in

her treatment, and prevention and treatment services must be provided directly to her children and family.

* + **Address won1en's unique health concerns.** Women possess distinctive risk factors associated with onset of use, have greater propensity for health-related consequences from drug and alcohol consumption, exhibit higher risks for infectious diseases associated with drug use, and display greater frequency of various co-occurring disorders. Moreover, women who abuse substances are more

likely to encounter problems associated with

reproduction, including fetal effects from substance use during pregnancy, spontaneous abortion, infertility, and early onset of menopause. Substance abuse treatment needs to address women's unique health concerns throughout the course of treatment.

* **Endorse a developmental perspective.**

In general, women experience unique life course issues. Specific to women who abuse substances, these life course issues, along with developmental milestones, impact their patterns of use, engagement in treatment, and recovery. Substance use and abuse affect women differently at different times in their lives. It is important to consider age-specific and other developmental concerns starting with the assessment process and continuing through continuing care and long-term recovery.

* **Attend to the relevance and influence of various caregiver roles that women often assun1e throughout the course** of **their** lives. Regardless of substance abuse, women are more likely to assume primary caregiving responsibilities for

their children, grandchildren, parents, and other dependents. These roles may heavily influence a woman's willingness to seek help for substance abuse, and also may interfere with her ability to fully engage in the treatment process or to adhere to treatment recommendations.

* **Recognize that ascribed roles and gender expectations across cultures affect societal attitudes toward women who abuse substances.** Whether or not a woman neglects her roles as a caregiver, engages in alcohol

or drug-induced sexual activity, continues to use despite pregnancy, or uses sex to secure her next supply of drugs or alcohol, women with substance use disorders are significantly stigmatized by societal attitudes

and stereotypes of women who drink and use drugs. As a result, women may experience feelings of shame associated with their use and the consequences of their use.

* **Adopt a trauma-informed perspective.** Current and past violence, victimization, and abuse greatly affect many women

Creating the Context **5**

who abuse alcohol and drugs. Substance abuse treatment approaches need to help women find safety, develop effective coping strategies, and recover from the effects of trauma and violence.

* + **Utilize a strengths-based model for women's treatn1ent.** A strengths-based approach builds on the woman's strengths and uses available resources to develop and enhance resiliency and recovery skills,

deepen a sense of competency, and improve the quality of her life. These strengths

may include personality traits, abilities, knowledge, cultural values, spirituality, and other assets; while resources may involve supportive relationships, environments, and professional support.

* + **Incorporate an integrated and multidisciplinary approach to women's treatment.** Treatment needs to integrate current knowledge, research, theory, experience, and treatment models from diverse disciplines critical to understanding women and substance abuse treatment.

In addition to incorporating and blending information from the mental health, women's health, and social and behavioral sciences fields, treatment providers must network

and collaborate with other agencies to provide comprehensive case management and treatment planning to address the complexity of biopsychosocial and cultural issues that women may exhibit throughout treatment.

* + **Maintain** a **gender-responsive treatn1ent environment across settings.** Effective treatment for women begins with a collaborative environment that is nurturing, supportive, and empowering. Women with substance use disorders are more likely

to remain in a treatment setting that feels familiar and safe, includes their children, utilizes proactive case management, and fosters the development of supportive relationships across the continuum of care.

* + **Support the development of gender­ cmnpetency** specific **to wonieu's** issues. Administrative commitment and vigilance is needed to ensure that staff members are provided gender-specific training and

supervision to promote the development of gender competency for women.

###### Women's Biopsychosocial Uniqueness

There is notable evidence to suggest that gender does make a difference. Whether examining risk factors to relapse potential, biological aspects to psychological issues, or treatment engagement

to attrition rates, empirical evidence suggests that gender differences do exist in substance use disorders. For women, unique biopsychosocial and developmental issues create or intensify these differences, which require specific treatment needs across the continuum of care of substance use disorders.

This TIP is based on the premise that women are biopsychosocially unique in ways relevant to substance use, substance use disorders, and the treatment of these disorders. Specifically, this TIP takes the following position: There are biopsychosocial factors that may affect

a significant proportion of women across the continuum of substance abuse services.

The knowledge of these factors will likely assist the substance abuse counselor in better

understanding and responding to the treatment needs of female clients.

Not only do women face numerous obstacles to entering and remaining in treatment, they also have specific needs while in treatment. Some obstacles stem from the frequently low economic status of women, the likelihood that they are custodial parents, the greater incidence of trauma and violence in female clients, and the societal stigma of substance abuse.

Additional treatment needs stem from a greater incidence of co-occurring mental disorders among female clients, and the growing realization that women respond better to treatment approaches that are supportive rather than confrontational and that promote relationships and positive connections among other clients in recovery and treatment providers.

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Supported by research, this section highlights the biopsychosocial uniqueness of women

and the impact that these characteristics may have on the onset of use, the development and progression of substance abuse and dependence, and the treatment of substance use disorders.

The unique biopsychosocial characteristics are divided into three segments: biological and psychological, social, and developmental. This

section does not focus on specific populations or on biopsychosocial, cultural, or developmental issues that are common in both men and women.

Biological and Psychological

Differences between women and men in genetics, physiology, anatomy, and sociocultural expectations and experiences lay the foundation-that women have unique health concerns related to substance use disorders as well as elevated risk for certain co-occurring physical and mental issues or disorders. This segment highlights and outlines the unique physiological and psychological issues that need attention across the continuum of care.

1. **Women have different physical responses to substances.**

Women have different physical responses to substances and typically display a quicker progression from initial use to the development of health-related problems (Antai-Otong 2006; Mann et al. 2005). Women become intoxicated after drinking smaller quantities of alcohol than men. For women who drink, they are affected more by alcohol consumption due to higher blood alcohol concentrations, proportionately more body fat, and a lower volume of body water to dilute alcohol.

Women develop substance use disorders and health-related problems in less time than do men, and this effect is known as telescoping. While research has studied the differences in metabolism with alcohol intake, studies

highlighting gender differences with illicit drugs is limited (Brady and Ashley 2005; Greenfield and O'Leary 2002; Sherman 2006). A few preliminary studies (Katz et al. 2004) have identified perceptual differences between men

and women asserting that women report more intense or positive effects; yet findings across studies are inconclusive. Chapter 3 of this

TIP provides a review of physical responses to substance use, beginning with the factors that influence these reactions including, but not limited to, ethnicity, acculturation, and aging.

1. **Women with** substance use **disorder** have **greater susceptibility to** as **well** as **earlier onset of** serious **medical problems and disorders.**

In general, women develop alcohol-related physical health problems at lower doses and over shorter periods of time than do men. Less evidence is available on gender differences regarding the effects and health consequences of other illicit drug use, but women also appear to have higher rates of health problems resulting from other substances (Sherman 2006). From moderate to heavy use, drugs and alcohol consumption increase specific health risks and physical disorders among women.

Alcohol consumption significantly increases risk for breast and other cancers (Bagnardi et al. 2001; Key et al. 2006; Tiemersma et al. 2003), osteoporosis in premenopausal women (Sampson 2002), peripheral neuropathy,

and cognitive impairments (Flannery et al. 2007; Sohrabji 2002). Overall, women

develop cirrhosis and heart muscle and nerve damage **with** fewer years of heavy drinking in comparison to men. Likewise, illicit drug use is associated with greater risk for liver and kidney diseases, bacterial infections, and opportunistic diseases. Chapter 3 presents an overview of the physiological effects and consequences of alcohol and drug use, including nicotine, among women.

1. **Women who abuse substances have specific health issues and medical needs related to gynecology.**

Routine gynecological care is fundamental to the prevention or early detection of a variety of serious health problems among women with substance use disorders, including cervical, breast, and other cancers; HIV/AIDS; and other infectious diseases. Evidence supports the havoc substances play on reproductive

Creating the Context 7

processes, such as the role of heavy alcohol use on infertility and drug use on menstrual cycles (Lynch et al. 2002; Reynolds and Bada 2003; Tolstrup et al. 2003). Even though gynecological concerns are frequently one of the main health concerns identified by women in substance abuse treatment, many young and low-income women have never had a gynecological examination.

Moreover, women over 40 with substance use disorders are less likely to have received a mammogram than other women of similar age (Carney and Jones 2006). Refer to chapter 3 for more **information** on gynecological consequences related to substance use disorders.

1. **In treating women of childbearing age who have a substance use disorder, pregnancy** is **a significant concern.**

Women who are abusing or are dependent on alcohol or other drugs may not realize they are pregnant. At times, women may mistakenly associate early signs of pregnancy as symptoms related to use or withdrawal from substances. Often, women who are pregnant and using alcohol and illicit drugs do not begin prenatal care until well into their pregnancies. Some of the most negative effects of substance use on the developing embryo can occur in the first weeks of pregnancy.

Adequate prenatal care often defines the difference between routine and high-risk pregnancy and between good and bad pregnancy outcomes. Timely initiation of prenatal care remains a problem nationwide, and it is overrepresented among women with substance use disorders. In part, the threat of legal consequences for using during pregnancy and limited substance abuse treatment facilities (only 14 percent) that offer special programs

for pregnant women (SAMHSA 2007) are key obstacles to care.

Numerous medical concerns can result from substance use during pregnancy as well as from detoxification and the medications used to treat substance use disorders. Thus, identification, comprehensive case management, and integrated services are essential in addressing these significant threats. The following chapters

provide information on negative consequences of alcohol and drug use during pregnancy (chapter 3), specific screening questions and tools (chapter 4), engagement strategies and programming for pregnant women (chapter 5), and retention and review of treatment issues and needs for pregnant women with substance use disorders, including co-occurring disorders (chapter 7).

1. **Wmuen who abuse substances are 1uore likely than other women to have co­ occurring disorders.**

In general, women with substance use disorders are more likely to meet diagnostic criteria for mood disorders specific to depressive symptoms, agoraphobia with or without panic attacks, posttraumatic stress, and eating disorders (Hudson et al. 2007; Piran and Robinson 2006; Tolin and Foa 2006). For women, literature suggests that the onset of psychiatric disorders is apt to precede substance use disorders. For instance, women who experience depression

are more prone to develop alcohol problems after their first depressive episode (Caldwell et al. 2002; Wang and Patten 2002). Chapter 2 of this TIP addresses risk factors for substance use disorders, including the role of other psychological disorders. Chapter 4 offers screening tools to help counselors identify the need for further assessment due to presenting psychological symptoms. Chapter 7 identifies treatment needs and strategies for the more prevalent psychological symptoms and disorders among women **with** substance use disorders, including trauma, posttraumatic stress and other anxiety disorders, and mood and eating disorders.

1. **Women who have substance use disorders are more likely to have been physically or sexually tramuatized and subjected to interpersonal violence.**

A high proportion of women with substance use disorders have histories of trauma, often perpetrated by persons they both knew and trusted. These women may have experienced sexual or physical abuse, domestic violence, or witnessed violence as a child. Studies have

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consistently found that rates of sexual abuse in both childhood and adulthood are higher for women than for men, and that a lifetime history of sexual abuse ranges from 15 to 25

percent (Leserman 2005; Tjaden and Thoennes 1998). Similarly, prevalence of lifetime domestic violence among women in the United States ranges from 9 to 44 percent, depending on the employed definition of domestic violence in each study (for review, see Thompson et al. 2006; Wilt and Olson 1996). While race/ethnicity is not generally associated with interpersonal violence, lower socioeconomic status appears to be associated with greater prevalence.

Women who have been abused as children are more likely to report substance use disorders as adults (Kendler et al. 2000). In a large study of female twins (*n=3* ,536), childhood sexual abuse was associated with a greater likelihood of lifetime alcohol use, having the first drink at an early age, and alcohol dependence (Sartor et al. 2007). Likewise, physical and sexual dating violence were found to be "significant independent predictors of substance use" in other research (Silverman et al. 2001). Among women seeking treatment for crack/cocaine abuse/dependence, a history of sexual trauma was associated with a greater number of health issues related to substance use, dependence on a greater number of substances, and a greater number of substance abuse treatment episodes (Young and Boyd 2000). In a study focused on the severity of childhood trauma among men and women who were dependent on cocaine, only a history of childhood trauma among

women created a greater susceptibility to relapse and escalation in use after relapse (Hyman et al. 2008).

Numerous studies on interpersonal violence have found a similar reciprocal relationship between substance abuse and domestic violence (Kilpatrick et al. 1997; Swan et al. 2000; Tjaden and Thoennes 1998, 2000, 2006). Rates of partner abuse appear highest for women who use cocaine/crack (Swan et al. 2000) or

methamphetamine (Cohen et al. 2003). However, women with substance use disorders and a history of physical abuse (from a known person,

not necessarily a partner) are more likely to enter substance abuse treatment than women with substance use disorders who don't have such a history (Walton-Moss and McCaul 2006).

Clinical issues related to childhood sexual and physical abuse, interpersonal violence, and trauma are addressed throughout this TIP. More specific information is covered in the following chapters:

*Chapter 2* addresses risk factors (including interpersonal violence, sexual abuse,

and other traumas) associated with the development of substance use disorders.

*Chapter 4* provides general screening and assessment guidelines, including tools for sexual victimization, childhood abuse, and interpersonal violence.

*Chapter* 7 highlights the treatment needs and interventions for these specific populations.

For more comprehensive reviews of domestic violence and child abuse, refer to TIP 25 *Substance Abuse Treatment and Domestic Violence* (CSAT 1997b); TIP 36 *Substance Abuse Treatmentfor Persons with Child Abuse and Neglect Issues* (CSAT 2000b); and the planned TIP *Substance Abuse and Trauma* (CSAT **in** development h).

**Social**

1. **Significant relationships and family history play an integral role in the initiation, pattern of use, and continuation of substance abuse for won1eu.**

From a sociocultural perspective, women (more than men) tend to define themselves in terms of their webs of social relationships and obligations. Relationships with others have special significance for many women. Hence, family history may have a more profound effect on initiation of use among women than men. Women with alcohol use disorders are also more likely than men to report having had alcohol dependent parents, other alcohol dependent relatives, and dysfunctional family patterns (Jennison and Johnson 2001; Nelson-Zlupko et al. 1995).

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Women are more likely to be introduced to and initiate alcohol and drug use through significant relationships including boyfriends, spouses, partners, and family members. This influence does not stop with initiation; it extends to greater use and higher incidence of substance use disorders when they have partners who abuse substances (Klein et al. 2003). In comparison to men, women with substance

use disorders are more likely to have intimate partners who also have substance use disorders (Brady and Ashley 2005; Lex 1991; Riehman

et al. 2003; Wright et al. 2007). In this **TIP,** chapter 2 addresses initiation, risk factors, and patterns of substance use and substance use disorders among women across the lifespan.

1. **Significant relationships and other adult family members may substantially influence and impact women's behavior associated with treatment seeking, support for recovery, and relapse.**

Women may have less support from family/ partners than do men for seeking treatment. Women with alcohol problems are more likely to be left by their partners at the time of entry into treatment (Lex 1991), and their partners are less likely to stay with them after completion of treatment. Unless they themselves are

involved in treatment or recovery, partners with substance use disorders may be unsupportive of women's treatment seeking (Brady and Ashley 2005). Couples in which both partners have substance use disorders and in those in which only the woman has a substance use disorder are more likely to spend time separated after treatment than are couples where only the man has a substance use disorder (Fals-Stewart et al. 1999). At the same time, husbands who do not themselves have substance use disorders expect greater change from wives with substance use disorders in treatment than if the circumstances were reversed (Fals-Stewart et al. 1999).

At times, substance use and the rituals associated with use may be a significant ingredient and symbol of intimacy and closeness in relationships. This history and relational pattern maymake recovery more challenging during and after treatment. Especially in the

early phase of recovery, women may believe that their decision to not use is or will be perceived as a direct threat against their significant relationship or family. Hence, women are more likely to relapse due to interpersonal problems and conflicts, and relapse is more likely to occur in the presence of a significant other (McKay et

al. 1996; Rubin et al. 1996; Sun 2007). To obtain more information on relational factors that influence women across the continuum from risk factors to relapse, see chapters 2, 5, 6, 7, and 8.

1. **For women, pregnancy, parenting, and childcare influence alcohol and drug consumption and increase the likelihood of entering and completing substance abuse treatn1ent.**

For many women, including those with substance use disorders, use of alcohol, tobacco, and/or illicit drugs significantly decreases after becoming aware of their pregnancy (Tough et

al. 2006). It is also not uncommon for women who abstained from alcohol, drugs, and tobacco during pregnancy to return to use after childbirth. So, the impact of pregnancy on patterns of consumption can present a double­ edged sword in treatment planning. On the one hand, pregnancy may represent a "'teachable moment" where motivation to protect the fetus can be expanded to help motivate the mother to make more permanent changes in her substance use behavior. On the other hand, progress toward recovery made by pregnant women

may be transient if this progress is primarily in response to the pregnancy itself.

Women are much more likely than men to enter treatment because it affects child custody

(Grella and Joshi 1999). If they are able to have their children in treatment, women are more likely to enter treatment, participate and stay in the program, and maintain abstinence (Brady and Ashley 2005; Lungren et al. 2003; Szuster et al. 1996). Likewise, women with children

in treatment have better treatment outcomes in major life areas in comparison to women who are without their children in treatment (Stevens and Patton 1998). Women in recovery see the support of their children as an essential ingredient for their recovery (Tracy and

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Martin 2007). Every chapter of this TIP covers issues pertaining to pregnancy, parenting, or child care, with specific attention to treatment modalities and treatment issues highlighted in chapters 5 and 7.

1. **Women are 1nore likely to encounter obstacles across the continumn of care as a result of caregiver roles, gender expectations, and socioecononric hardslrips.**
   * Women with substance use disorders have enhanced treatment needs related to pregnancy, care of children, and other caregiver roles. Familiarity with these gender-based experiences can contribute to effective treatment programming and successful treatment outcomes. To begin with, pregnancy itself can be an obstacle to treatment because substance abuse treatment programs are not always able to admit pregnant women or to provide the services required. Beyond pregnancy,

women often assume many other caregiver roles, and these roles can significantly interfere with treatment engagement and regular attendance at treatment services. Brady and Ashley (2005) reported that women are more likely to encounter difficulties surrounding treatment attendance due to family responsibilities. Often family expectations regarding responsibilities involve care for other family members and the need to attend to their significant relationship.

* + Most women with substance use disorders have to contend with economic and

social factors as well as individual and family issues to negotiate their recoveries successfully. Because women frequently earn less than menfor doing the same job, they face more economic barriers

to entering **and** staying in treatment than do men. Women are less likely than men to be able to pay out-of- pocket for treatment, have less access

to private health insurance, are less likely to have savings or other financial resources to support themselves while in treatment, and often cannot afford a

car to take them to treatment. According to NSDUH (SAMHSA 2003), 34 percent of women who reported they did receive substance use treatment indicated that they could not cover treatment costs

due to inadequate or nonexistent health insurance. As important, women with co-occurring serious mental illness and

substance use disorders were less likely to be employed full-time than women with only a substance use disorder (SAMHSA 2003). Many female clients need assistance with transportation; affordable, safe housing; and onsite child care and other services for their children. To obtain more specific information on obstacles pertinent to women in treatment, refer to chapter 5.

1. **Despite the m1ique challenges, women are more likely to engage in help-seeking behavior and in attending treatment after admission.**

Women are more likely to seek health and mental health services than are men. Studies have found that women with alcohol use disorders as well as drug use disorders marked with severity are either as likely as or more prone to initiate treatment than men (Moos et al. 2006; Weisner et al. 2001). Once women are admitted to substance abuse treatment, they are at least as likely as men to participate and

stay in treatment. Help-seeking behavior among women with substance use disorders appears

to remain consistent across time. In one study, Chatham et al. (1999) found that women, in comparison to men, were more likely to seek further help for both psychological issues and drug use 1 year postdischarge from a methadone maintenance program. Another study found that women were also more apt to seek help after a relapse (McKay et al. 1996). Refer to chapter 5 of this TIP for treatment engagement strategies that help reinforce help-seeking behavior.

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1. **Women report more interpersonal stressful life events.**

Overall, women report more interpersonal related stress **in** relation to negative affect whereas men report more legal and work­ related stressful life events (Kendler et al. 2001). This difference is likely a reflection of gender role expectations and socialization, and is evident among men and women in substance abuse treatment. Specifically, women entering treatment report a greater level of family and social problems as measured by the Addiction Severity Index (Green et al. 2002; Weiss et al. 1997). During the week prior to relapse and

on the initial day of relapse, women report interpersonal problems and negative affect as key stressors (McKay et al. 1996). For more information regarding interpersonal risk factors of use, relational treatment needs, and relapse risk factors associated with interpersonal stress among women, refer to chapters 2, 7, and 8, respectively.

1. **Women often take different paths in** accessing **treatn1ent for substance use disorders.**

Women are more likely than men to seek out physical and mental health treatment, including substance abuse treatment. They

are also more likely to make use of a variety of healthcare options including primary care and psychological counseling (Cherry and Woodwell 2002). Among women with substance use disorders, the most frequent source of referral to treatment was made by self-referral followed by the criminal justice system and other community referrals, including child protective services (Brady and Ashley 2005). Refer to chapter 2 of this TIP to review more information reoC-, ardinoC-, treatment admission characteristics among women.

1. **Women have unique client-counselor expectations and relational needs related to treallnent.**

Women's sociocultural role as caregivers predisposes them to define themselves **in** terms of social relationships and obligations. Through this lens, women are more likely

to view relationship building as an essential treatment ingredient. If attention is given to establishing and maintaining relationships across the continuum of care, women are more likely to initiate, engage, and successfully complete treatment. Women have identified several counselor characteristics that they believe contribute to treatment success-a projection of acceptance and care, trust and warmth, a non-authoritarian attitude, and a sense of confidence in their abilities (Fiorentine and Anglin 1997; Sun 2006). Likewise, women are more likely to stay in treatment longer if they receive more intensive and individual care, are able to maintain their parenting role while in treatment, and either stay within the same

treatment services or maintain a connection with treatment providers throughout the continuum of services, including continuing care. In this TIP, chapter 7 covers the main factors that influence retention; particular attention is given to women's treatment expectations surrounding environment, theoretical approach, therapeutic alliance, and counselor characteristics.

1. **Women are uniquely stigmatized in relationship to substance abuse.**

* StioC-, ma is a sioC,-nificant barrier to treatment and recovery. Ascribed roles and gender expectations across cultures affect societal attitudes toward women with substance abuse. The societal stigma toward women who abuse substances tends to be greater than that toward men, which can prevent women from seeking or admitting they need help. According to NSDUH (SAMHSA 2003), women who reported not receiving or not perceiving a need for treatment attributed social stigma as the primary reason.

Women who use alcohol and illicit drugs often have great feelings of shame and guilt, have low levels of self-esteem and self-efficacy, and often are devalued by other women and men. These feelings make it difficult for women to seek help or feel that they deserve to be helped. Additionally, women may carry internalized feelings of guilt and shame concerning their failure in maternal roles (Ehrmin 2001). Some women fear negative consequences, including

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mandatory involvement with child protective services, loss of child custody, or other

legal consequences, if their substance abuse

becomes known. Gender role expectations in many cultures result in further stigmatization of substance use, and additional challenges face women who are of color, disabled, older, lesbians, and poor. For additional information on gender socialization and the role of stigma associated with substance abuse across specific populations, review chapter 6. For additional discussion and material on stigmatization, review risk factors in chapter 2 and sociocultural obstacles in chapter 5.

**Developmental**

1. Women have unique life-course issues and events.

Over the past two decades, the substance abuse field has increasingly recognized the importance of developmental issues over the entire lifespan (Klitzner 1992; White 2006). Changes in physiology, emotional and social development, and cognitive capacity as well as changes in social roles and expectations have all been associated with substance abuse and its treatment. Many of these life course issues are different or more salient for women than for men. The following segment covers the main developmental milestones for women, and

additional information is interwoven throughout this TIP.

*Identity and gender expectations-the younger years:* During adolescence and young adulthood, young women are likely to face greater gender-based sociocultural expectations (Gilligan et al. 1990). Consistent with this notion is the finding that girls and young women may be more susceptible to substance use-related social influences than are boys (Dick et al.

2007). Substance use may play an essential role in exploring new experiences while forming identity, but it is as likely that substance use helps provide relief when identity formation and the negotiation of new gender role expectations becomes confusing or difficult (Arnett 2005).

***Educational, employment, and career*** *issues:* In a recent summary of women's career development, Fitzgerald and Harmon (2001; p. 226) concluded that "life is, in many ways, less gendered than it was in the 1970s"; however, "there are still ways in which life and its opportunities are partially controlled by gender stereotypes" and roles. Several writers have argued that "women's work lives are more complex than men's" (Fitzgerald et al.

1995; p. 76). For example, the need to balance career endeavors-education, training, and employment-with caregiver responsibilities is a major developmental task that more often than not is unique to women.

While younger women are more likely and able to invest in earlier career development than the women of 50 years ago (Arnett 2005), they still do not characteristically encounter the same career opportunities, and for many

women, early career aspirations may be placed on hold or pared down until years later due

to pregnancy and childcare responsibilities. Disparity in employment opportunities, income, healthcare insurance, and/or childcare support presents unique challenges for all women, but significantly impacts women with substance use disorders and women seeking substance abuse treatment. Overall, women with substance use disorders have more pronounced employment barriers than men with substance use disorders and women without substance use problems, including women who are recipients of the Temporary Assistance to Needy Families program (TANF; McCoy et al. 2007; Meara 2006).

*Pregnancy, parenting, and childcare issues:* This developmental milestone and the issues involving substance use disorders and treatment are covered in the above social section, item 3.

***Menopause:*** Menopause is a complex biopsychosocial transition for women. Rather than an event, menopause is a process that unfolds over many years as estrogen levels decrease. These decreases, in turn, maylead to a variety of physical and psychological symptoms, the onset of which may precede the

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cessation of fertility by as much as a decade (Stewart 2005). For some women, cessation of fertility occasions a re-examination of social roles, which may lead to depression or anxiety in some and a new sense of freedom in others. Studies evaluating the impact of hormonal changes on alcohol and drug metabolism

and the consequences of substance use on the development of menopause are limited. Yet, preliminary studies reflect potential effects even though research remains mixed and methodological issues are evident. Most

noteworthy, substance abuse and dependence may exacerbate postmenopausal risks for coronary heart disease, osteoporosis, and breast cancer in this population (Register et al. 2003).

*Caring for parents and partners:* Many more people than ever before are having to cope with caring for elderly parents in addition to the usual demands of work and family. The typical pattern is that sons offer financial

assistance, and daughters and daughters-in-law provide the time-consuming, hands-on care.

More than 60 percent of caregivers are female (National Alliance for Caregiving and American Association of Retired Persons [AARP] 2004).

An estimated 80 percent of informal care for elders is imparted on family caregivers

(International Longevity Center 2006), and these caretaking responsibilities can last 10 years or n1ore.

Women may be caught between the responsibilities of providing care to their parents or parents-in-law while simultaneously taking care of their own dependent children.

Time and energy spent caring for elderly parents often come at the expense of other family or occupational roles as well as self-care. Although unpaid family leave is now available to many workers, the demands of caring for an elderly parent force some women to make hard choices. They either have to reduce or stop work or have to find professional and institutional care. Some have had to switch to part-time work, pass up promotions, or quit their jobs altogether. This decision can lead to greater risk for living in poverty in the later years due to terminating

or decreasing hours of employment to care for aging parents (Wakabayashi and Donato 2006). For women with substance use disorders, the emotional, physical, and financial stressors are likely to exacerbate substance use. Moreover, unique obstacles exist for women with substance use disorders-balancing the need to care

for their parents and the need for their own substance abuse treatment.

***Longer life than male partners:*** Women are more likely than men to outlive their partners. According to the Centers for Disease Control and Prevention, the general life expectancy for women and men is 80.4 and 75.2 years, respectively. Data from the Census Bureau indicate that almost one-half of American women over the age of 65 are widowed (Fields and Casper 2001). A recent cross-sectional and longitudinal study of more than 70,000

American women ages 50-79 (Wilcox et al. 2003) found that widowed women were significantly more physically impaired than married women on a variety of measures, including general health and physical functioning, obesity, hypertension, and pain. Widowed women were also significantly lower in overall mental health and social functioning and significantly higher in depressed mood.

*The later years:* Various sources of data suggest that alcohol problems are ordinary events among the elderly, and estimates of the prevalence of heavy drinking or alcohol abuse range from 2 to 20 percent for this population (Benshoff and Harrawood 2003). There is also some suggestion that the baby-boom generation is more likely than earlier generations to have been exposed to drug and alcohol use and may drink or consume drugs at greater rates after age 65. The literature on the etiology of elder substance use disorders is limited, but spousal loss is one commonly cited factor (Benshoff and Harrawood 2003).

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##### Organization of this TIP

Scope

This TIP discusses treatment for women from diverse cultures, ethnicities, and sexual

orientations; women living in urban and rural areas; women who are pregnant, parenting, or without children; and women of all ages, socioeconomic classes, and histories. Although

alcohol and drug effects on fetuses and neonates are mentioned, the details and implications

for fetuses and neonates are not discussed in detail. Female adolescents are not addressed in this TIP. Whereas some adolescents' needs may parallel those of women, their developmental stage requires specialized treatment.

Information on treating adolescents can be found in TIP 32 *Treatment of Adolescents with Substance Use Disorders* (CSAT 1999d). Substance abuse treatment issues specific to male clients are addressed in the planned TIP *Substance Abuse Treatment and Mens Issues* (CSAT in development}).

Whenever possible, TIPs include empirical findings in support of practices they recommend. However, the field of substance abuse treatment is evolving and research can lag behind the innovations being pioneered in the field. Treatment recommendations included in this TIP are based on both consensus panelists' clinical experience and scientific literature.

When the research supports a particular approach, citations are provided.

Audience

The primary audience for this TIP is substance abuse treatment clinicians and counselors

who work with women. Secondary audiences include administrators, educators, researchers, policymakers for substance abuse treatment and related services, consumers, and other healthcare and social service personnel who work with women with substance use disorders.

Approach: Gender Responsive Treatment

This TIP draws on the systemic framework of Bronfenbrenner's ecological theory and CSAT's *Comprehensive Substance Abuse*

*Treatment Model for Women and Children* (see Appendix B). It is based on clinical practice and research centered on women. It is not derived primarily by comparing women with men. The knowledge, models, and strategies presented

are grounded in women's experiences and their unique biopsychosocial and cultural needs.

The basic elements and principles of gender­ responsive treatment are presented throughout this TIP, with suggestions and resources on how to implement such a system of care. Also presented are approaches to treating substance

use disorders among women; these employ model treatment programs, evidence-based and best practices, and other research on women's issues along with knowledge from related fields.

Guidelines for Readers

The consensus panel recognizes the realities of substance abuse treatment sometimes precludes implementing the wide array of services and programs recommended in this volume. Nevertheless, by presenting a variety of techniques for addressing the specific treatment needs of women, the panel hopes to increase sensitivity to these needs and options for improving treatment. A special feature

throughout the TIP, "Advice to the Clinician," imparts the TIP's most direct and accessible guidance for the counselor. Readers with basic backgrounds (such as addiction counselors or other practitioners) can study the Advice to the Clinician boxes for the most immediate practical guidance. Brief "Note(s) to the Clinician" and "Note(s) to the Clinician and Administrator" are offered to highlight specific issues in treatment services. The TIP also includes "Clinical Activity" inserts that provide counselors examples of practical individual or group activities that support specific treatment issues for women.

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Terminology

*African American:* The term is used to identify women who live in the United States and whose ancestors at some point arrived from Africa.

Although it blurs the distinction between women whose families came to this country from Caribbean nations and other countries and those who came directly from Africa, it is the term used by the U.S. Census Bureau and by SAMHSA and CSAT.

***Co-occurring disorders:*** The term "co-occurring disorders" refers to a diagnosis of substance use disorder and one or more mental disorders.

***Gender:*** This term is used not just as a biological category, but also as a social category meaning society or culture shapes the definition of gender and shapes the socialization of each woman.

Gender affects how women live their lives, see their roles and their expectations of themselves and others, view and interpret the world, and handle the opportunities open to them and the constraints placed on them. People enact their gender in the world through transactions with others and are guided by social and cultural values and conceptions (West and Zimmerman 1987).

*Gender responsive:* "Being gender-responsive (or woman-centered) refers to the creation

of an environment-through site selection, staff selection, program development, and

program content and materials-that reflects an understanding of the realities of women's and girls' lives and that addresses and responds to their challenges and strengths" (Covington 2007, p. 1).

***Hispanic/Latina:*** The use of the Spanish feminine term "Hispanic/Latina" indicates a woman of Hispanic heritage. The phrase

"Hispanic/Latino" refers to men only or a group of men and women. The phrase "women of color" refers in this document to women of racial and cultural groups other than Caucasian, as well as women who consider themselves biracial or multiracial.

*Substance abuse:* The term "substance abuse" refers to both substance abuse and substance dependence (as defined by the *Diagnostic*

*and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* [DSM-IV-TR] [American Psychiatric Association {APA} *2000a])* because substance abuse treatment

professionals commonly use the term "substance abuse" to describe any excessive use of addictive substances. In this TIP, the term refers to the use of alcohol as well as other substances of abuse. Readers should attend to the context

in which the term occurs to determine the possible range of meanings it covers; in most cases, however, the term refers to all varieties of substance use disorders described by DSM-IV­ TR.

# 2 Patterns of Use: From Initiation to Treatment

##### Overview

**In This Chapter**

Initiation of Use Among Women

Risk Factors Associated with Initiation of Substance Use and the Development of Substance Use Disorders Among Women

Patterns and Prevalence of Substance Use Among Women

Prevalence of Substance Abuse and Dependence Among Women

This chapter addresses patterns of substance use, abuse, and dependence using a continuum beginning with initial risk factors and concluding with common attributes associated with women entering treatment for substance use disorders. Information pertaining to risk factors linked to initiation of use, abuse of alcohol and other drugs, and/or the development of substance dependence is explored. Also examined are the potential reasons for initiation of use, means of introduction, and other characteristics of drug and alcohol patterns of use among women. In addition, to shed light on common patterns, this chapter provides prevalence rates of substance use, abuse, and dependence, including specific populations of women and substances as well as psychosocial characteristics of women who enter treatment.

While this section provides a wealth of information on the unique psychosocial issues and patterns of use among women to aid in program development, the essential value for clinicians is recognizing that substance use disorders do not occur in a vacuum. By gathering information on the specific risk factors associated with initiation of use, people of introduction, and other individual characteristics, clinicians can identify clients' potential barriers to treatment engagement and retention along with high-risk relapse triggers. For example, women who identify that their initial use was influenced by a sexual relationship and that their present use involves a significant relationship will be more likely threatened by the potential loss of a relationship if they continue in treatment and recovery. In addition, the client may be greatly influenced by phone calls from boyfriends, spouses, or significant others that lead to premature termination of treatment. Thus, risk factors associated with either the initiation

or continuation of use can assist clinicians in identifying specific problem areas, in anticipating intervention strategies for these

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