# Substance Abuse Treatment: Addressing the Specific Needs of Women

## A Treatment Improvement Protocol

## TIP 51


Substance Abuse and Mental Health Services Administration
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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.

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.

# Consensus Panel

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**Norma B. Finkelstein, Ph.D., M.S.W.**
Executive Director
Institute for Health & Recovery
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**Juana Mora, Ph.D.**
Professor
Northridge Chicano/a Studies Department
California State University, Northridge
Northridge, California

## Workgroup Leaders

**Karen Allen, Ph.D., R.N., FAAN**
Professor/Chair
Department of Nursing
Andrews University
Berrien Springs, Michigan

**Hortensia Amaro, Ph.D.**
Distinguished Professor
Center on Health and Social Science Research Director
Institute on Urban Health Research
Northeastern University
Boston, Massachusetts

**Stephanie S. Covington, Ph.D., LCSW**
Co-Director
Center for Gender and Justice
Institute for Relational Development
La Jolla, California

**Francine Feinberg, Psy.D., CISCW**
Executive Director
Meta House
Whitefish Bay, Wisconsin

**Beth Glover Reed, Ph.D.**
Associate Professor
Social Work and Women's Studies
School of Social Work
University of Michigan
Ann Arbor, Michigan

**Brenda L. Underhill, M.S., CAC**
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Underhill and Associates
El Cerrito, California

## Panelists

**Belinda Biscoe, Ph.D.**
Assistant Vice President for Public and Community Services
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University of Oklahoma
Norman, Oklahoma

**Vivian B. Brown, Ph.D.**
Founder, Board Member Emeritus
PROTOTYPES
Culver City, California

**Margaret A. Cramer, Ph.D.**
Clinical Psychologist/Instructor
Massachusetts General Hospital
Boston, Massachusetts

**Gloria Grijalva-Gonzales**
Certified Sr. Substance Abuse Case Manager/
Counselor
Allies Project
San Joaquin County
Stockton, California

**Tonda L. Hughes, Ph.D., R.N.**
Professor
Department of Health Systems Science
University of Illinois at Chicago
Chicago, Illinois

**Marty A. Jessup, Ph.D., R.N., M.S.**
Associate Adjunct Professor
Department of Family Health Care Nursing
Institute for Health and Aging
University of California, San Francisco
San Francisco, California

**Karol A. Kaltenbach, Ph.D.**
Clinical Associate Professor of Pediatrics,
Psychiatry and Human Behavior
Director, Maternal Addiction Treatment
Education and Research
Department of Pediatrics
Jefferson Medical College
Thomas Jefferson University
Philadelphia, Pennsylvania

**Robin A. LaDue, Ph.D.**
Clinical Psychologist
Department of Psychiatry and
Behavioral Sciences
University of Washington
Renton, Washington

**LaVerne R. Saunders, B.S.N., R.N., M.S.**
Founder/Partner
Dorrington & Saunders and Associates
Framingham, Massachusetts

**Starleen Scott-Robbins, M.S.W., LCSW**
Women's Treatment Coordinator
Best Practice Consultant
Developmental Disabilities and Substance Abuse
Services
Division of Mental Health
North Carolina Department of Health and
Human Services
Raleigh, North Carolina

**Sally J. Stevens, Ph.D.**
Executive Director
Southwest Institute for Research on Women
University of Arizona
Tucson, Arizona

**Sharon Wilsnack, Ph.D.**
Professor
Department of Clinical Neuroscience
Medical School for the Public
School of Medicine & Health Sciences
University of North Dakota
Grand Forks, North Dakota

**Rita Zimmer, M.P.H.**
Founder
Women in Need, Inc.
New York, New York

# Editorial Board

# KAP Expert Panel and Federal Government Participants

**Barry S. Brown, Ph.D.**
Adjunct Professor
University of North Carolina at Wilmington
Carolina Beach, North Carolina

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Professor of Clinical Psychiatry
College of Medicine
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Cincinnati, Ohio

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Community Treatment and Correction Center, Inc.
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University of Maryland Baltimore County
Baltimore, Maryland

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Independent Consultant
Brown University
Providence, Rhode Island

**Jerry P. Flanzer, D.S.W., LCSW, CAC**
Chief, Services
Division of Clinical and Services Research
National Institute on Drug Abuse
Bethesda, Maryland

**Michael Galer, D.B.A.**
Chairman of the Graduate School of Business
University of Phoenix - Greater Boston Campus
Braintree, Massachusetts

**Renata J. Henry, M.Ed.**
Director
Division of Alcoholism, Drug Abuse, and Mental Health
Delaware Department of Health and Social Services
New Castle, Delaware

**Joel Hochberg, M.A.**
President
Asher & Partners
Los Angeles, California

**Jack Hollis, Ph.D.**
Associate Director
Center for Health Research
Kaiser Permanente
Portland, Oregon

**Mary Beth Johnson, M.S.W.**
Director
Addiction Technology Transfer Center
University of Missouri—Kansas City
Kansas City, Missouri

**Eduardo Lopez, B.S.**
Executive Producer
EVS Communications
Washington, DC

**Holly A. Massett, Ph.D.**
Academy for Educational Development
Washington, DC

**Diane Miller**
Chief
Scientific Communications Branch
National Institute on Alcohol Abuse
and Alcoholism
Bethesda, Maryland

**Harry B. Montoya, M.A.**
President/Chief Executive Officer
Hands Across Cultures
Espanola, New Mexico

**Richard K. Ries, M.D.**
Director/Professor
Outpatient Mental Health Services
Dual Disorder Programs
Seattle, Washington

**Gloria M. Rodriguez, D.S.W.**
Research Scientist
Division of Addiction Services
NJ Department of Health and Senior Services
Trenton, New Jersey

**Everett Rogers, Ph.D.**
Center for Communications Programs
Johns Hopkins University
Baltimore, Maryland

**Jean R. Slutsky, P.A., M.S.P.H.**
Senior Health Policy Analyst
Agency for Healthcare Research & Quality
Rockville, Maryland

**Nedra Klein Weinreich, M.S.**
President
Weinreich Communications
Canoga Park, California

**Clarissa Wittenberg**
Director
Office of Communications and Public Liaison
National Institute of Mental Health
Kensington, Maryland

## Consulting Members:

**Paul Purnell, M.A.**
Social Solutions, L.L.C.
Potomac, Maryland

**Scott Ratzan, M.D., M.P.A., M.A.**
Academy for Educational Development
Washington, DC

**Thomas W. Valente, Ph.D.**
Director, Master of Public Health Program
Department of Preventive Medicine
School of Medicine
University of Southern California
Alhambra, California

**Patricia A. Wright, Ed.D.**
Independent Consultant
Baltimore, Maryland

# Foreword

The Treatment Improvement Protocol (TIP) series fulfills the Substance Abuse and Mental Health Services Administration's (SAMHSA'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 requirements. 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 reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people in need of behavioral health services. We are grateful to all who have joined with us to contribute to advances in the behavioral health field.

**Pamela S. Hyde, J.D.**
Administrator
Substance Abuse and Mental Health Services Administration

Director
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration

# 2 Patterns of Use: From Initiation to Treatment

## In This Chapter



## Overview

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

specific risks, and in developing a compatible treatment plan and an individually tailored continuing care plan.

## Initiation of Use Among Women

The reasons for initiation of substance use and the subsequent development of substance use disorders involve a network of factors among women (Maharj et al. 2005). No one biopsychosocial characteristic is solely responsible for substance initiation, abuse, or dependence. For women, initiation of substance use typically begins after an introduction of the substance by a significant relationship such as a boyfriend, partner, or spouse. Reasons for initiation of substance use vary among women; they frequently report that stress, negative affect, and relationships are very influential in first use. Depending on the physiological effects of the substance, some women report they initiate use due to a desire to lose weight or to have more energy; e.g., methamphetamine use (Brecht et al. 2004).

Women initiate substance use at an older age than do males. According to SAMHSA's Treatment Episode Data Set (TEDS; SAMHSA 2004), the average age of first use of drugs or alcohol for females is almost 20 years old. In reviewing gender differences in initiation of use between males and females, a key ingredient that appears paramount is the opportunity to use. While females currently have fewer restrictions than in the past, they generally encounter more parent-imposed restrictions and constraints on activities, greater parental monitoring, and higher expectations surrounding responsibilities in the home. These restrictions often limit drug and alcohol exposure and opportunity to use (van Etten and Anthony 2001). Yet, when women across ethnically diverse groups have the same opportunity as men, they are just as likely to initiate use. In recent years, women have had more opportunities and greater availability in accessing drugs and alcohol (van Etten et al. 1999).

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

Why one woman uses a substance without becoming dependent while another progresses to abuse and dependence is not entirely clear. Substance use disorders have complex and interrelated causes. For women, some factors are associated only with initiation of use, while other factors are associated with progression from initial use to substance dependence; e.g., co-occurring disorders (Agrawal et al. 2005). Just as some factors increase the likelihood of women developing substance abuse problems, others decrease those chances. For example, having a partner can be a risk factor if that person abuses alcohol or drugs, but having a supportive, caring partner who does not use alcohol or drugs can be a protective factor. In this section, risk factors associated with initiation of use, ongoing alcohol and drug involvement, and alcohol and drug abuse and dependence are explored.

### Familial Substance Abuse

Substance use disorders aggregate in families: relatives of people with substance use disorders are more likely to have a disorder. In all likelihood, both genetic and environmental factors play important and interconnected roles. Most research on familial aggregation has been done on alcohol use disorders and on male subjects. Reviews of several studies indicate that parental substance abuse can influence the development of substance use disorders in their children (Finkelstein et al. 1997; Heath et al. 1997). Jennison and Johnson (2001) cite a growing body of research on the risk for adult children of parents who abuse alcohol. The literature indicates that women are affected by familial substance abuse as much as men, with

a prevalence of alcohol dependence from 10 to 50 times higher than women who do not have a parent who abuses substances.

Twin and adoption studies have established an important role for genetic influences in the etiology of alcohol use disorders in men. Some studies show that genetic factors appear to be important in women as well, making women similarly vulnerable to substance abuse from a genetic standpoint (Johnson and Leff 1999; Merikangas and Stevens 1998; Pickens et al. 1991). A study of 1,030 female twins found that alcohol use disorders were consistently higher in identical twins than in non-identical twins and suggested that women's genetic likelihood of developing an alcohol use disorder is in the range of 50 to 60 percent (Kendler et al. 1992). Kendler and Prescott (1998) found that among women, genetic risk factors have a moderate effect on the probability of ever using cannabis and a strong effect on the likelihood of heavy use, abuse, and, probably, dependence.

However, on the whole, the evidence for genetic influence on the development of alcohol use disorders in women is less consistent than for men. Interpretation of the literature is complicated by methodological issues, such as small sample sizes. Some research suggests that differences between men and women exist in the sets of genes that influence alcohol use disorder risk or perhaps in the interactions of genes contributing to alcohol use disorder risk with other genetic or cultural factors (Prescott 2002). A study of women who were adopted found that early-life family conflict and psychopathology in the adoptive family interacted with a biological background of alcohol use disorders. Among women with at least one biological parent with an alcohol use disorder, conflict or psychopathology in the adoptive family increased the probability of alcohol abuse or dependence (Cutrona et al. 1994).

A number of possible explanations could account for this genetic and behavioral parental impact (Heath et al. 1997; Johnson and Leff 1999). Parents who use alcohol and illicit drugs sometimes are unable to supervise their children and protect them from physical or sexual abuse by other family members or strangers (Moncrieff and Farmer 1998). They more often are emotionally unavailable to nurture and help their children. According to Johnson and Leff's (1999) review of the literature, alcohol use by parents is both directly linked to alcohol use by children and indirectly linked to stress, less parental supervision, and greater emotional volatility. Jessup's (1997) review indicates that when parents have substance use disorders, it signals to a child that coping with problems by using alcohol and illicit drugs is acceptable behavior.

## Family of Origin Characteristics

Across ethnic and cultural population groups, major risk factors for substance initiation and dependence among women include chaotic, argumentative, blame-oriented, and violent households. As a general tenet, women who grew up in families where they take on adult responsibilities as a child, including household duties, parenting of younger children, and emotional support of parents, are more likely to initiate drug and alcohol use. Women who are dependent on substances are more likely to have a history of over-responsibility with their family of origin (Nelson-Zlupko et al. 1995). While prevalence of alcohol dependence appears consistently higher among women who report parental alcohol abuse regardless of the number of adverse childhood experiences (Anda et al. 2002), these experiences, characterized by childhood abuse and various forms of dysfunctional households, significantly increase early initiation of use on or before the age of 14 (Dube et al. 2006).

## Marital Status

Women (18 to 49 years of age) who are married have a lower rate of alcohol or illicit drug abuse or dependence than women of any other marital status (SAMHSA 2003). History of divorce is positively associated with illicit drug use, not drug dependence, among women (Agrawal et al. 2005). Approximately 11 percent of divorced

or separated women and 16 percent of women who have never married (in age range of 18 to 49 years) abuse or are dependent on alcohol or an illicit drug compared to only 4 percent of married women (SAMHSA 2004).

## Effect of Partner Substance Abuse

The "interaction, assistance, and encouragement of other people" are major factors in women's substance use and abuse (Finkelstein 1996, p. 30). One study found that to some degree partners influence each other's drinking patterns (Wilsnack et al.1998*b*). Men who drink alcohol more frequently than their partners influence them to drink more often, and women who drink lightly influence their partners to drink less (Wilsnack et al. 1998*b*).

Women dependent on illicit drugs are more likely than males dependent on illicit drugs to have partners who use illicit drugs (Lex 1995). Although alcohol and marijuana use often begins with peer pressure during adolescence, women are likely to be introduced to cocaine and heroin by men (Amaro and Hardy-Fanta 1995; Henderson et al. 1994). Some women continue using alcohol and illicit drugs to have an activity in common with their partners or to maintain the relationships. The man often supplies drugs, and the woman becomes dependent on him for drugs. Among women with partners who have alcohol-related problems, they are more likely to report mental health problems including mood, anxiety, and quality-of-life problems as well as substance use disorders (Dawson et al. 2007).

The dynamic of one partner being the supplier and the other using the drug to maintain the relationship is present also in some same-sex relationships. A few studies have examined the effects of partner substance abuse in lesbian relationships, especially the association between substance use and violence, but little is actually known (Hughes and Norris 1995; Schilit et al. 1990).

Women are at risk of contracting HIV/AIDS and hepatitis from sharing needles or having sexual relations with men who inject drugs or have sex with men. Some women may have unrealistic notions about intimacy, assume their partners are monogamous, or fear alienating their partners by demanding safe sex practices. Women with a history of abuse may have particular problems negotiating the use of these practices.

Although ending a bad relationship can lessen stress, it also causes psychological distress (Hope et al. 1999; Horwitz et al. 1996) and can increase alcohol use and related problems (Chilcoat and Breslau 1996; Neff and Mantz 1998; Power et al. 1999), especially among women (Fillmore et al. 1997; Horwitz et al. 1996). The situation is more complicated when a couple has a child and the woman may feel unable to leave the child's father for emotional or financial reasons (Amaro and Hardy-Fanta 1995).

Partners may prevent women from entering or staying in treatment (Tuten and Jones 2003). A study of male partners of women in treatment for crack/cocaine found that most of the men accepted their partners' drug use as long as the women managed to care for the home and children (Laudet et al. 1999). This study notes the difficulty of involving male partners in women's treatment. Despite the fact that nearly two-thirds of the men said they supported their partners in treatment, they found this support to be passive and inconsistent. Laudet and colleagues (1999) suggest a number of possible reasons for the male partners' detachment: the males' own alcohol and drug use, desire to maintain the status quo, different treatment goals, preoccupation with their own treatment, and fear of stigma.

## Personality Measures

Novelty-seeking was positively associated more with initiation of illicit drug use than with

**Protective Factor—Parental Warmth:** If a woman comes from a family of origin that has high parental warmth, she is less likely to initiate use, abuse substances, or become dependent on alcohol or other substances (Agrawal et al. 2005)

**Protective Factor—Partner Support:** In their study of nearly 4,500 women, Jennison and Johnson (2001) found that a good marriage was protective against the development of alcohol abuse in women with a familial history of alcohol abuse. Partners can be the key motivators in successful interventions that bring a woman to treatment. Treatment readiness and willingness to accept help are higher in women whose partners have been in treatment (Riehman et al. 2000).

progression from use to abuse/dependence (Agrawal et al. 2005). Among women, sensation-seeking (risk-taking personality) has significant effects on substance use. One study (VanZile-Tamsen et al. 2006) that examined the impact of personality constructs on health risk behavior among women showed that sensation-seeking has large indirect effects on risky sexual behavior, affiliation with risky partners, and drinking and illicit drug use behavior, and that sensation-seeking is more strongly associated with substance use than with sexual risk behavior. Premorbid personality risk factors that lay the foundation for substance abuse (besides depressive features) include obsessiveness and anxiety, difficulty in regulating affect and behavior (such as temper tantrums and frequent tearfulness), and low self-worth and ego integration (Brook et al. 1998). According to Page (1993), a negative self-perception of physical attractiveness is associated with increased illicit drug use.

## Sexual Orientation

Studies show higher rates of substance use and dependence in women who have sex with women compared with heterosexual women (Bickelhaupt 1995; Cochran et al. 2000; Diamant et al. 2000; UCLA Center for Health Policy Research 2005). Hughes and Wilsnack (1997) conclude that lesbians differ from heterosexual women in that they are less likely to abstain from alcohol, have higher rates of alcohol problems, and do not decrease alcohol intake as much with age. Conversely, Drabble and Underhill (2002) note that two studies found no significant differences in levels of drinking between lesbians and heterosexual women and that lesbians who did not drink were more likely to report being in recovery. Heffernan (1998) suggests these comparable rates of drinking among lesbian and heterosexual women are perhaps the result of a greater emphasis on sobriety in the lesbian community over the past decade.

Studies have reported greater prevalence of marijuana use in comparison to other illicit drugs among lesbians (Cochran et al. 2004). In a study reporting elevated rates of illicit drug use among lesbian and bisexual women, marijuana was the most prevalent (33 percent), followed by opioids other than heroin (15.1 percent), and tranquilizers (11.6 percent; Corliss et al. 2006). Lesbians who have moderate or high-risk levels of use, measured by patterns of drug use and severity, were also more likely to report depressive symptoms, and this pattern of depressive symptoms is reflected in Hispanic/Latina and Asian populations (Cochran et al. 2007). Among younger lesbians and bisexual women, they appear to be most likely to abuse prescription drugs (Kelly and Parson 2007). Empirical studies reveal that lesbians are more likely to smoke than heterosexual women (Hughes and Jacobson 2003).

**Protective Factor—Religious and Spiritual Practices:** Numerous studies (for review, see Matthews et al. 1998) highlight that higher levels of personal devotion, religious affiliation, and religious beliefs (defined as religiosity) reduce the risk for substance use and dependence. A female twin study found a negative association between religious beliefs and illicit drug use (Agrawal et al. 2005)—that religiosity is associated with a reduced risk for substance abuse. Consistent with other studies (Kendler et al. 1997; Kendler et al. 2003), this study suggests that religiosity is a protective factor in substance use and abuse, and that faith-based approaches may serve as a potential relapse prevention strategy.

Lesbians who have a history of child sexual abuse possess a heightened risk for lifetime alcohol abuse in comparison to lesbians without a similar abuse history (Hughes et al. 2007). Adolescent females and women who are either struggling with issues or prejudice surrounding sexual orientation also have greater risks in initiating and maintaining drug and alcohol use (McKirnan and Peterson 1992). More information on treating lesbian clients is available in *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals* (CSAT 2001*b*).

## History of Interpersonal Violence, Childhood Sexual Abuse, and Other Traumas

A history of traumatic events including, but not limited to, sexual and physical assaults, childhood sexual and physical abuse, and domestic violence, are significantly associated with initiation of substance use and the development of substance use disorders among women (Agrawal et al. 2005; Brady and Ashley 2005; Hawke et al. 2000; Pettinati et al. 2000). One review found a lifetime history of trauma in 55 to 99 percent of women who abused substances, compared with rates of 36 to 51 percent in the general population (Najavits et al. 1997). Although not every woman who has a history of trauma develops posttraumatic stress disorder (PTSD), it is important to note that traumatic experiences are associated with substance use and subsequent substance use disorders. Several interpretations have been offered to explain why substance abuse often accompanies trauma. Studies (Grayson and Noelen-Hoeksema 2005; Jarvis et al.1998; Schuck and Wisdom 2001; Testa et al. 2003; Ullman et al. 2005) suggest that some survivors of sexual and/or physical abuse may use substances to self-medicate their depression or the anxiety that results from the abuse. Some survivors who use primarily cocaine and amphetamines may be trying to increase their vigilance against further victimization. Others with low self-esteem may use alcohol to increase their sociability. Conversely, substance use disorders increase a woman's vulnerability to additional trauma, decrease her ability to

### *Note to Clinicians*

For those women who are more likely to seek out novel events and thrive on risk-taking behavior or those women who are accustomed to living in high stress or in crisis, one of the challenges in maintaining recovery is learning to engage in day-to-day activities without seeking out or creating these situations. Some women may be so used to higher levels of stress that when life becomes a little more settled without the use of alcohol and drugs, they may experience a sense of boredom, uncomfortable feelings, or a sense of being down or depressed. In recovery, women may place themselves in circumstances that are high risk for relapse by returning to old risk-taking behaviors or by creating stressful situations to offset these feelings.

As a clinician, it is important to anticipate these behaviors and reactions and to begin teaching strategies to manage these experiences. Using anxiety management strategies can be invaluable, but it is important to teach these techniques as early as possible to help build an arsenal of coping skills. Women need to learn about their accustomed risk-taking levels and premorbid levels of stress and the subsequent consequences if they engage in sensation-seeking behaviors. By developing alternative, healthy behaviors, some women will discover they don't need to maintain the same level of stress to function as in the past, while other women will learn they can exchange their destructive desire for excitement with other recovery-oriented activities; e.g., enrolling in an exercise class (with medical clearance) or telling their recovery story at a 12-Step speakers meeting.

defend herself, alter her judgment, and draw her into unsafe environments.

Kilpatrick and colleagues (1997) speak of the "vicious cycle" of substance abuse and violence, in which violence is both a risk factor and a consequence of substance abuse. TIP 25, *Substance Abuse Treatment and Domestic Violence* (CSAT 1997*b*), defines domestic violence as "the use of intentional emotional, psychological, sexual, or physical force by one family member or intimate partner to control another" and provides an array of means of abuse: "verbal, emotional, and physical intimidation; destruction of the victim's possessions; maiming or killing pets; threats; forced sex; and slapping, punching, kicking, choking, burning, stabbing, shooting, and killing victims" (p. 1).

The actual introduction to substances by a significant other can be a way of increasing control and establishing power over some women. While rates of domestic violence vary across studies, it is evident that there is a significant relationship between violence and substance initiation, abuse, and dependence. In one survey study assessing the prevalence of domestic violence among women in substance abuse treatment, 60 percent of women reported either current or past domestic violence, 47 percent reported current domestic violence at treatment intake, and 39 percent reported either physical or emotional abuse in the past year leading up to treatment (Swan et al. 2000). Moreover, the prevalence of interpersonal violence and substance use extends to pregnant women who are drug dependent. In another study on prevalence of violence and pregnant women, 73 percent reported a lifetime history of physical abuse. Approximately 33 percent of women in substance abuse treatment who were pregnant reported having physical fights with their current partner in the past year (Velez et al. 2006). In the first analysis of evaluating the role of substance use as a means of coping among women who have experienced domestic violence (Kaysen et al. 2007), the results support the self-medication hypothesis in that women use alcohol as a means of managing painful affect.

## Co-Occurring Substance Use and Mental Disorders

Women are more likely than men to have co-occurring mental and substance use disorders (see chapter 8 and TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* [CSAT 2005*e*]). According to the National Comorbidity Study of women diagnosed with alcohol abuse, 72.4 percent have lifetime co-occurring mental disorders and 86 percent of women diagnosed with alcohol dependence have co-occurring disorders (Kessler et al. 1997). In comparison to men, women are more likely to have multiple comorbidity (three or more psychiatric diagnoses in addition to substance use disorder; Zilberman et al. 2003). Various literature on co-occurring disorders highlights the role of substance abuse as a means of self-medicating distressing affect. While differences are noted in prevalence rates of co-occurring disorders among women of specific ethnic populations, Corcoran and Corcoran (2001) assert, based on their retrospective study, that gender (specifically female), appears to play a more salient role than ethnicity in endorsing the use of substances to manage negative affect.

For women, anxiety disorders and major depression are positively associated with substance use, abuse, and dependence and are the most common co-occurring diagnoses (Agrawal et al. 2005). Other common mental disorders in women with substance use disorders are eating disorders and PTSD, a common sequel to violence and trauma. In a study screening women veterans for substance abuse and psychiatric disorders, 57 percent of the women who screened positive for depression,

**Protective Factor—Coping Skills:** Engaging in problemsolving skills, mobilizing support from others, and learning to cope with one's feelings are key protective ingredients (Mrazek and Haggerty 1994).

eating and panic disorders, and PTSD also screened positive for substance abuse (including tobacco use). This sample demonstrated that women with a positive screen for psychiatric conditions were twice as likely to have abused drugs in the last year (Davis et al. 2003). While it is likely that mental disorders can play a primary role in initiating substance use to gain relief, it is as important to acknowledge that psychiatric disorders may occur as a consequence of substance use or develop independently, yet concurrently, of the current pattern of substance use.

Preliminary investigations and discussions suggest that some co-occurring mental disorders may be likely risk factors for the initiation of substance use and the subsequent development of substance use disorders (such as anxiety disorders and major depression), while other co-occurring disorders may be more likely to occur after the development of substance use disorders (Conway and Montoya 2007). For many women, the onset of the mental illness may precede the substance abuse, particularly in cases of PTSD (Brady and Randall 1999). One study reveals that women with PTSD were five times more likely than women without PTSD to have substance use disorders (Brady et al. 2000). A review of several studies reveals that current PTSD rates among women who abuse substances range between 14 and 60 percent (Brady 2001; Najavits et al. 1998; Triffleman 2003), and that women who use substances are still more than twice as likely to have PTSD than men (Najavits et al. 1997). The planned TIP, *Substance Abuse and Trauma* (CSAT in development *h*), provides more information on this topic.

Regarding eating disorders (anorexia nervosa and bulimia nervosa), women who are diagnosed with these disorders are more likely to develop alcohol use disorders later on (Franko et al. 2005). Specifically, the behavioral pattern of purging, but not bingeing, appears to be associated more strongly with substance use. This finding is consistent with a theory that overeating or bingeing competes with substance use for the reward sites in the brain (Kalarchian et al. 2007; Kleiner et al. 2004; Warren et al. 2005), and that obesity may be a protective factor against developing substance use disorders.

## Discrimination

Discriminatory acts range from mundane slights to devastating violent acts. Women may experience varied levels of discrimination—based on gender, race, ethnicity, language, culture, socioeconomic status, sexual orientation, age, and disability—that affect their substance use and may affect their recovery (see chapter 6). For some women, substance abuse may become a way of coping with the additional stresses of discrimination. When women experience more than one type of discrimination, the effect can be compounded (Krieger 1999). Discrimination can result in fewer educational and employment opportunities, lower socioeconomic status, fewer choices in housing, and poorer health outcome (Mays et al. 2007). Less access to health care and difficulty in funding treatment due to a lack of health insurance can result in later referral for substance abuse treatment. These circumstances can lead directly and indirectly to negative health consequences and psychological distress, requiring special considerations during treatment (Krieger 1999).

## Acculturation

Studies have found that as immigrants become increasingly acculturated into American society, and even as African Americans move closer to mainstream European/Caucasian lifestyles, alcohol and drug use increases. Acculturation can involve intergenerational conflict and feelings of disconnection, a struggle for cultural identity, and feelings of grief and loss related to the life left behind—all of which can put a woman at risk for substance abuse. For example, foreign-born Mexican Americans and foreign-born non-Hispanic Caucasians are at significantly lower risk for substance use disorders than are their American-born counterparts (Grant et al. 2004). Second- and third-generation Hispanics/Latinas are more likely than their mothers to use alcohol and illicit drugs (Mora 2002). A

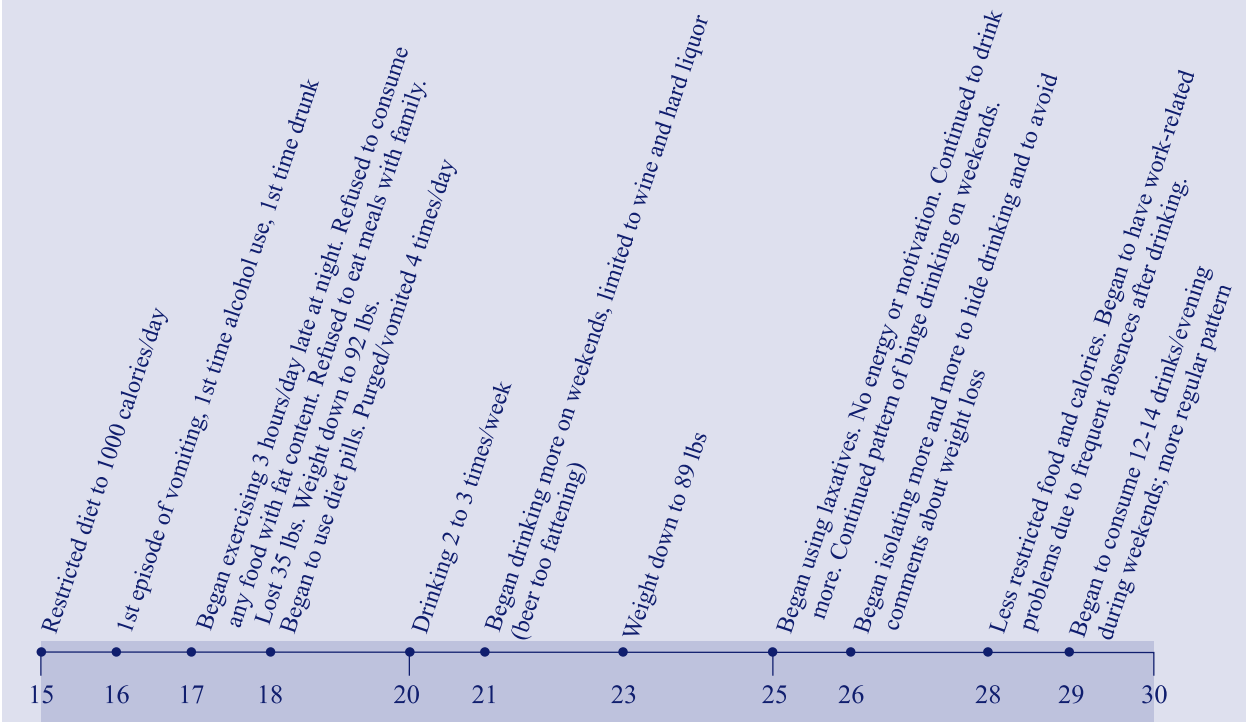
## Clinical Activity: Timeline Exercise

When working with individuals with co-occurring disorders, it is often a challenge to understand the history and development of symptoms and the chronological relationship between each disorder. While it would be valuable to understand the temporal relationship between disorders and to determine which set of symptoms and disorder came first, it is generally information that is difficult to obtain. Nonetheless, clinicians can help clients gain awareness of the interrelationship between disorders and symptoms and how one disorder may exacerbate the other or serve as a coping mechanism to manage symptoms. To lay the groundwork to help clients understand this relationship, a simple timeline exercise can be implemented to highlight the prevalence and presenting symptoms across time.

**Directions**: On a piece of paper, draw a straight line from birth to current age. Mark the line either in 1-year or 5-year increments depending on the age of the client and the duration of the disorders. Start with one disorder and mark the approximate onset of the initial symptoms, then write in the symptoms starting with the initial occurrence (approximate) and add the subsequent symptoms across the timeline. Once you have completed one disorder, go back (use a different color pen or marker) and do the same for the next. Use the timeline as a tool to promote discussion. Don't forget to process feelings that may surface during this exercise. **Note**: As a clinician, it can be enticing to add other variables from the start, but usually it is better to start out simple and then return to the timeline in the next individual or group session to explore other issues, such as rating severity of use on the timeline

A sample timeline is provided below. This timeline was developed for a patient with a history of an eating disorder (anorexia nervosa) and alcohol dependence. Not all symptoms have been noted on this timeline for either disorder.

## Clinical Activity: Sample Timeline



suggested explanation for this increase in use among younger Latinas is conflicting cultural expectations; their mothers and grandmothers are more constrained by traditional cultures.

### Socioeconomic Status

Women with substance use disorders are more likely to have lower incomes and less education and are less likely to be employed. Employment status appears to be a factor associated with alcohol and drug abuse and dependence. Drug abuse and dependence are higher among women who are unemployed; in 2003, 12.5 percent of women aged 18 to 49 who were unemployed abused or were dependent on alcohol or an illicit drug compared with 8 percent of women who were employed full time (SAMHSA 2004). The temporal relationship between unemployment and the development of substance use disorders is rather complex and not well understood.

## Patterns and Prevalence of Substance Use Among Women

This section covers specific prevalence rates associated with women's initiation of substance use. Similar to males, females initiate use based on, but not limited to, alcohol and drug availability, level of ease in obtaining the substances, price of substances, the ratio between perceived drug benefit versus perceived risk associated with use, and general attitude toward substance use. Yet, women typically display different patterns of use with alcohol, illicit and prescription drugs, and tobacco. The following segment highlights these unique patterns.

### Prevalence of Substance Use: Alcohol, Illicit Drugs, Prescription Drugs, and Tobacco

#### *Alcohol and illicit drugs*

SAMHSA's National Survey on Drug Use and Health (NSDUH) interviews yearly more than 67,000 persons ages 12 or older to assess their use of alcohol and illicit drugs and their symptoms of substance abuse or dependence during the past year (SAMHSA 2007). Results of NSDUH for 2006 indicate that 45.2 percent of females ages 12 or older used alcohol during 2006, and 6.2 percent reported current illicit drug use. Figure 2-1 (p. 29) provides more specific information about the use of illicit drugs, alcohol, and tobacco by females ages 12 and older.

#### *Prescription drugs*

An analysis of data from the National Medical Expenditures Survey shows women not only use significantly more prescription drugs than men, they also use significantly more prescription drugs with addictive properties. Compared with men, women are 48 percent more likely to use a prescription drug that can be abused (Simoni-Wastila 2000). According to the NSDUH 2004 survey, between 2003 and 2004, the number of persons aged 12 or older with lifetime nonmedical use of pain relievers increased from 31.2 million to 31.7 million including the use of Vicodin, Lortab, Lorcet, Percocet, Percodan, Tylox, hydrocodone products, OxyContin, and oxycodone products (SAMHSA 2005). The NSDUH 2003 survey found that 55 percent of new people who used these prescription drugs were female (SAMHSA 2004).

#### *Tobacco*

The importance of tobacco use should not be underestimated in a discussion of substance abuse. The negative physical consequences are well documented and can be fatal—increased risk for cardiovascular disease and stroke; chronic obstructive pulmonary disease; and lung, bladder, and other cancers—and specific risks are related to gender (see chapter 3).

Tobacco use among American women has decreased from a high of 34 percent in 1965 to 23.3 percent in 2006 (SAMHSA 2007). Among females ages 12 or older, 22.2 percent smoked cigarettes in the past month during 2006. Less than 1 percent of women reported current use of a smokeless tobacco product, and 2.1 percent reported smoking cigars. Women who use smokeless tobacco (ST) reported using ST to manage weight and in response to mood states.

## *Six Patterns Associated with Women's Substance Use*

**1. Narrowing of the Gender Gap:** In comparing male and female rates of alcohol use across 10 years (Grant et al. 2006), there is significant evidence of the gender gap narrowing. Overall, younger adult females are more likely to mirror male patterns of alcohol and illicit drug use than older females. This shrinking gender gap for alcohol and drug use has been noted across ethnic groups, especially among younger women.

**2. People of Introduction and Relationship Status:** Women are more likely to be introduced to and initiate alcohol and drug use through significant relationships including boyfriends, spouses, partners, and relatives. According to the National Center on Addiction and Substance Abuse and Columbia University (CASA) research report, females are often introduced to substances in a more private setting (2003). In addition, marital status plays an important role as a protective factor in the development of substance use disorders.

**3. Drug Injection and Relationships:** Even though women are less likely to inject drugs than men, research suggests that women accelerate to injecting at a faster rate than men (Bryant and Treloar 2007). When women inject drugs for the first time, they are more likely than men who are first-time injectors to be introduced to this form of administration by a sexual partner (Frajzyngier et al. 2007). Women are more likely to be involved with a sexual partner who also injects. While various personality and interpersonal factors influence needle sharing among women (Brook et al. 2000), women are more likely to inject with and borrow needles and equipment from their partner, spouse, or boyfriend. Among women who use with their sexual partners, Bryant and Treloar (2007) highlight a division of labor where men are responsible for obtaining, purchasing, and injecting the drug for them. Thus, needle sharing and drug using with a sexual partner may engender a sense of emotional intimacy among women or reflect inequity of power in the relationship. Other "people of introduction" besides sexual partners are groups that are predominantly female. While women may initiate drug injection through relational means, it is important to recognize that some women are as likely to initiate drug injection on their own.

**4. Earlier Patterns Reflect Later Problems:** Drinking low to moderate levels of alcohol in early adulthood is a predictor of later heavy drinking and alcohol-related substance use disorders among women (Andersen et al. 2003; Morgen et al. 2008). In addition to amount of alcohol intake, frequency of use appears positively associated with risk of alcohol dependence, particularly for women (Flensborg-Madsen et al. 2007). Females who begin smoking at a young age are more likely to initiate alcohol and drug use than females who do not smoke.

**5. Responsibilities and Pattern of Use:** Women are more likely to temporarily alter their pattern of use in response to caregiver responsibilities. As an example, women are likely to curtail or establish abstinence of alcohol and illicit drugs while pregnant (SAMHSA 2004), even though they are as likely to resume use later on. In addition, some women report that they use stimulants to help meet expectations associated with family responsibilities (Joe 1995).

**6. Progression and Consequences of Use:** Women experience an effect called telescoping (Piazza et al. 1989), whereby they progress faster than men from initial use to alcohol and drug-related consequences even when using a similar or lesser amount of substances. While extensive research is available pertaining to the telescoping effect of alcohol and alcohol-related consequences among women, more recent research (Hernandex-Avila et al. 2004; Ridenour et al. 2005) supports a preliminary finding—a similar pattern of rapid progression for illicit drugs. While women have a greater biological vulnerability to the adverse consequences of substance use, it is important to note that variations in progression and the biopsychosocial consequences of substance use may also be linked to socioeconomic status, racial/ethnic differences, and age (Johnson et al. 2005). As an example, African Americans generally begin regular alcohol use later than most population groups yet demonstrate more rapid transition from initiation of use to abuse.

In addition, women reported that initiation of use was significantly influenced by other females who use (Cohen-Smith and Severson 1999).

Data from the 1997–1998 National Center for Health Statistics' National Health Interview Survey revealed that among racial or ethnic groups, American-Indian and Alaska-Native women have the highest prevalence of tobacco use with 34.5 percent; Asian- or Pacific-American women have the lowest prevalence at 11.2 percent (Office of the Surgeon General 2001*b*). Women with more education tend to smoke less than women with less education. According to the survey, the lowest rates among people who smoke were for women with more than 16 years of education, and the highest rates were for women with 9 to 11 years of education.

There is increasing evidence that children of parents who smoke cigarettes are more likely to smoke than the children of parents who do not smoke. Although some studies show conflicting results, girls seem to be more influenced by their parents' smoking and are particularly more likely to model maternal behavior. This applies not just to smoking but also to cessation. The Office of the Surgeon General (2001*b*) reports one study that found when mothers stopped smoking, it helped delay or deter smoking in adolescent daughters, but not in sons.

Although there is debate about the relevance of the "gateway" concept (in which use of one substance leads to use of other more "dangerous" substances), many studies show that tobacco use precedes alcohol and drug use. Young women in particular who smoke tobacco are more likely than young women who do not smoke to drink alcohol or use drugs, especially when they begin smoking at a young age (Ellickson et al. 1992; Lai et al. 2000; Torabi et al. 1993). Based on these studies, associated behaviors and environmental factors play a probable role in initiating tobacco, alcohol, and drug use.

## Prevalence of Substance Use Patterns Among Women Who Are Pregnant

NSDUH includes questions about the use of alcohol, illicit drugs, tobacco, and pregnancy status among women ages 15 to 44; results show past-month rates for substance use are curtailed substantially during pregnancy (see Figure 2-2 on p. 30; SAMHSA 2008). These rates are likely to be conservative because they reflect only past-month use, not use during the entire pregnancy. They also are limited to women who were aware of their pregnancies at the time of the survey. Responses are affected by an unknown degree of stigma associated with using substances during pregnancy.

Among pregnant women ages 15 to 44 years, 5 percent reported using illicit drugs in the past month, based on combined 2006 and 2007 NSDUH data. This rate is significantly lower than the rate among women ages 15 to 44 who were not pregnant (10.0 percent). The rate of past-month cigarette use was also lower among those who were pregnant (16.4 percent) than it was among those who were not pregnant (28.4 percent). Alcohol use followed a similar pattern among pregnant women ages 15 to 44 with an estimated 11.6 percent reporting past-month alcohol use. This rate was significantly lower than the rate for nonpregnant women in the same age group (53.2 percent).

These data are encouraging, indicating that women tend to reduce their substance use during pregnancy. However, women's reduction of substance use during pregnancy appears to be temporary (SAMHSA 2008). NSDUH data suggest that women ages 15 to 44 use alcohol, tobacco, and illicit drugs less during pregnancy but are likely to resume substance use after pregnancy.

Women who continued to use illicit drugs occasionally or regularly after their last menstrual period are more likely to have a

## *Figure 2-1*
## *Use of Illicit Drugs, Alcohol, and Tobacco by Females Aged 12 or Older, Past Year and Past Month, Numbers in Thousands and Percentages, 2006*

| | Past Year Number | Past Year Percent | Past Month Number | Past Month Percent |
|---|---|---|---|---|
| **Any Illicit Drug** | 15,007 | 11.8 | 7,816 | 6.2 |
| Marijuana (includes hashish) | 9,785 | 7.7 | 5,162 | 4.1 |
| **Any Illicit Drug Other Than Marijuana** | 9,310 | 7.4 | 4,019 | 3.2 |
| Cocaine | 2,116 | 1.7 | 797 | 0.6 |
| Crack | 453 | 0.4 | 182 | 0.1 |
| Heroin | 184 | 0.1 | 77 | 0.1 |
| Hallucinogens (LSD, PCP, Ecstasy) | 1,593 | 1.3 | 428 | 0.3 |
| Inhalants | 875 | 0.7 | 257 | 0.2 |
| Nonmedical Use of Any Psychotherapeutics | 7,509 | 5.9 | 3,141 | 2.5 |
| Pain Relievers | 5,427 | 4.3 | 2,206 | 1.7 |
| Tranquilizers | 2,622 | 2.1 | 801 | 0.6 |
| Stimulants/Methamphetamine | 1,677 | 1.3 | 599 | 0.5 |
| Sedatives | 519 | 0.4 | 250 | 0.2 |
| **Any Tobacco** | 34,751 | 27.4 | 29,484 | 23.3 |
| **Alcohol** | 79,140 | 62.5 | 57,283 | 45.2 |
| Binge Alcohol Use | — | — | 19,276 | 15.2 |
| Heavy Alcohol Use | — | — | 4,172 | 3.3 |

*Source:* SAMHSA 2007.

higher number of pregnancies, less prenatal care, greater likelihood of substance use among family and friends, and greater severity of substance use (Derauf et al. 2007; Shieh and Kraavitz 2006). Continued substance abuse during pregnancy is a major risk factor for fetal distress, developmental abnormalities, and negative birth effects. It is also associated with delayed prenatal care, and it is quite likely that this delay is exacerbated as a result of fears pertaining to potential legal consequences (Jessup et al. 2003). Timely prenatal care for pregnant women who continue to use illicit drugs provides a significant buffer against adverse pregnancy outcomes, including premature births, small for gestational age status, and low birth weight (El-Mohandes et al. 2003; Quinlivan and Evans 2002).

# Prevalence of Substance Abuse and Dependence Among Women

## The Shrinking Gender Gap of Substance Abuse and Dependence

Even though studies have consistently shown a greater prevalence of substance use disorders among men, evidence is also mounting on the narrowing of the gender gap for these disorders (see Figure 2-3 on p. 31). According to the NSDUH 2006 survey, females were as likely as males to abuse or be dependent on substances between 12 and 17 years of age, while older adolescent males and females continue to show a greater gender gap in percentages of substance-related disorders. In comparing epidemiologic surveys from 1992 to 2002, an analysis found a significant increase in risk for alcohol abuse and dependence among women born after 1944, except for African-American women (Grucza et al. 2008).

## Across the Life Span

As women become older, the prevalence of substance abuse and dependence becomes lower (Grant et al. 2006). The 2003 NSDUH estimated that 15.7 percent of women ages 18 to 25 abused or were dependent on alcohol or an illicit drug in the past year compared with 1.5 percent of those ages 50 or older (see Figure 2-4 on p. 32). However, it is important to remember that women remain vulnerable to substance use, abuse, and dependence and its consequences across their life spans. As women encounter major life transitions, they are at a heightened risk for substance use and abuse (Poole and Dell 2005).

***Figure 2-2***
***Past-Month Substance Use, Based on Combined 2006 and 2007 Data: National Survey on Drug Use and Health (NSDUH), 2007***

| | *Pregnant, Aged 15–44* | *Not Pregnant, Aged 15–44* |
|---|---|---|
| Any alcohol use | 11.6 percent | 53.2 percent |
| Binge alcohol use | 3.7 percent | 24.1 percent |
| Any illicit drug use | 5.2 percent | 9.7 percent |
| Cigarette use | 16.4 percent | 28.4 percent |

*Source*: SAMHSA 2008.

## Characteristics of Treatment Admissions Among Women

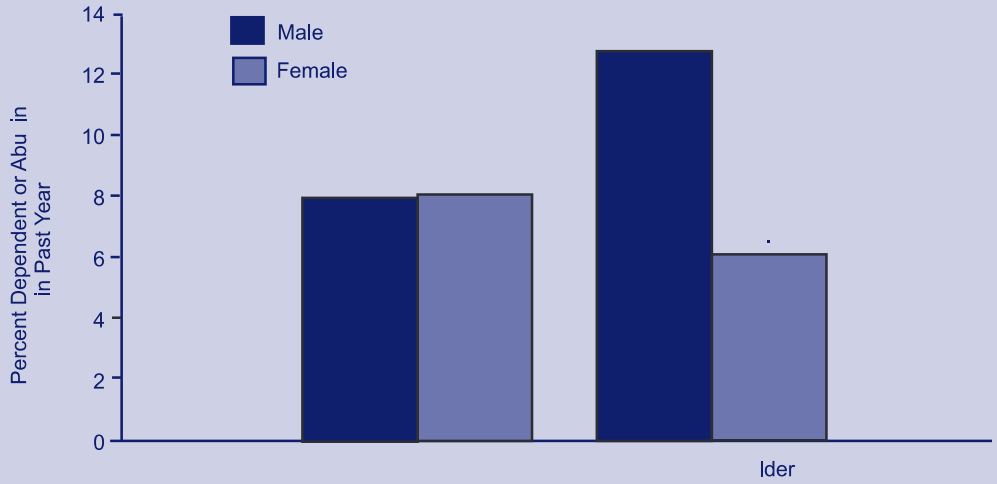
Data from treatment admissions provides considerable information on the patterns of substance use among women. Yet caution needs to be taken when generalizing this information across the entire population of women who have substance use disorders, since most women who have substance use disorders never receive treatment. According to TEDS data (SAMHSA 2004), women are less likely to report alcohol as their primary substance of abuse compared with males. Although alcohol is still the primary substance of abuse, women are more likely than men to be in treatment for drug use. For women, 37 percent report that opiates (20 percent) or cocaine (17 percent) are their primary substances of abuse.

While women often receive other healthcare services prior to identification of substance use disorders, referrals from healthcare providers (other than alcohol and drug use treatment providers) are one of the lowest referral routes to treatment for women. Currently, self-referral, social service agencies, and the criminal justice system are the primary sources of referral to treatment for women (Brady and Ashley 2005; SAMHSA 2004). In comparison to men, women are more likely to be identified with a substance use disorder through child protective services (Fiorentine et al. 1997).

Women who enter treatment are more likely to identify stress factors as their primary problem rather than substance use (Green et al. 2002; Thom 1987). They also exhibit more severity and problems related to substance use upon entering substance abuse treatment, including medical and psychological problems (Arfken et al. 2001). This heightened level of severity and symptomotology may, in part, be a result of delayed access to treatment due to various barriers, a reflection of rapid progression from initiation to alcohol and drug use consequences (telescoping), a manifestation of a woman's tendency to consume alcohol and use cocaine more frequently than men (Pettinati et al. 2000), or the lack of appropriate screening or identification of treatment need until severity is paramount.

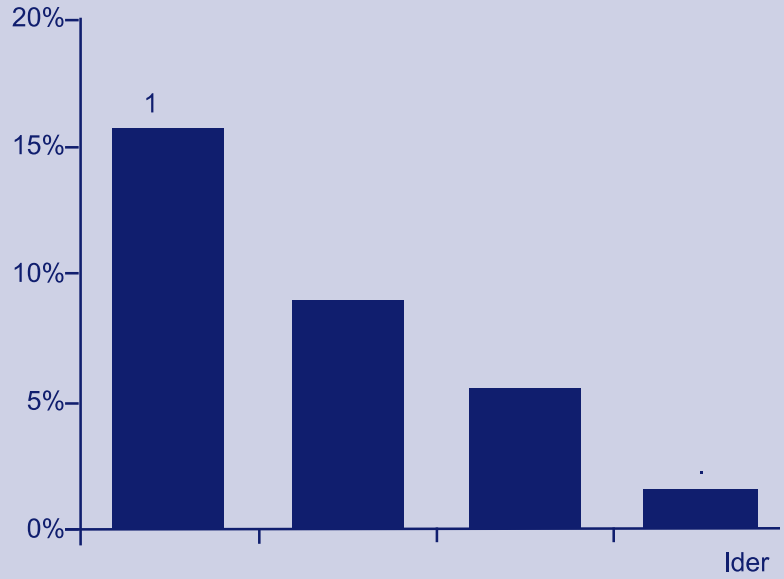
In Figure 2-5 (p. 33), the percentage of female admissions to substance abuse treatment

***Figure 2-3***
***Percentages of Past-Year Abuse of or Dependence on Alcohol or Any Illicit Drug by Gender and Age, 2006***




*Source:* SAMHSA 2007.

## *Figure 2-4*
## *Percentages of Past-Year Abuse of or Dependence on Alcohol or Any Illicit Drug Among Women Aged 18 or Older by Age Group: 2003*




*Source:* SAMHSA 2007.

programs by racial/ethnic groups is shown. For more detailed information on ethnicity and substance abuse, refer to chapter 6. In addition, the planned TIP, *Improving Cultural Competence in Substance Abuse Treatment* (CSAT in development *a*) provides additional information on ethnicity and substance abuse patterns.

TEDS data also provide information about substance preferences for women of specific population/ racial/ethnic groups. Figure 2-6 shows the percentage of treatment admissions by substance for each ethnic or racial group of women. Except for the "alcohol plus another substance" category, only the woman's primary substance of abuse is indicated in the table; the prevalence of polydrug abuse cannot be determined (SAMHSA 2004).

As Figure 2-6 (p. 34) indicates, the primary substance of abuse reported on admission of Caucasian and American-Indian/Alaska-Native women is alcohol. Asian- and Pacific-American women reported methamphetamine most often. African-American women were more likely to name crack/cocaine as the primary substance of abuse, whereas some subgroups of Hispanic/Latina women were more likely to enter treatment for heroin use. For most ethnic or racial groups, alcohol and a secondary drug were abused by the next largest percentage of women.

In 2002, women constituted about 30 percent of admissions for substance abuse (Brady and Ashley 2005), but they represented a larger proportion of admissions for prescription and over-the-counter (OTC) drug abuse (46 percent; OAS 2004*b*). Depending on treatment level, admission rates varied from 29 percent in hospital inpatient facilities to 39 percent in outpatient methadone programs. Women were admitted in notable proportions for all types of prescription and OTC drug abuse: 47

percent for prescription narcotics, 44 percent for prescription stimulants, 50 percent for tranquilizers, 51 percent for sedatives, and 42 percent for OTC medications (OTC drugs include aspirin, cough syrup, and any other medication available without prescription). The majority of individuals admitted for prescription and OTC drug treatment were Caucasian (88 percent; OAS 2004*b*).

According to TEDS data (OAS 2004*c*), 15,300 (4 percent) of women admitted to substance abuse treatment in 2002 were pregnant at the time of admission. Compared with the women in treatment who were not pregnant at admission, the pregnant women in treatment were more likely to report cocaine/crack (22 versus 17 percent), amphetamine/methamphetamine (21 versus 13 percent), or marijuana (17 versus 13 percent) as their primary substance of abuse. Alcohol was the primary substance of abuse among almost one-third of women aged 15 to 44 (31 percent) who were not pregnant at the time of admission. In contrast, only 18 percent of women who were pregnant at admission reported alcohol as their primary substance of abuse.

***Figure 2-5***
***Percentage of Admissions to Substance Abuse Treatment Programs by Racial/Ethnic Group in 2006***

| Group | Percentage of Total Admissions |
|---|---|
| Female Admissions | 31.8 |
| Caucasian | 20.1 |
| African American | 6.4 |
| Hispanic (Mexican Origin) | 1.6 |
| Hispanic (Puerto Rican Origin) | 0.8 |
| American Indian/Alaska Native | 0.9 |
| Asian/Pacific Islander | 0.4 |

*Source:* HHS, SAMHSA, OAS 2008

## Note to Clinicians

For a woman entering treatment, the tendency to focus on problems or stressors other than her substance abuse is quite normal. Women are socialized to assume more caregiver roles and to focus attention on others. Even if she has not appropriately cared for others (such as her children) during her addiction, it does not mean that she will not see this as an important issue immediately upon entering a detoxification or treatment program. The clinician needs to appreciate this gender difference; instead of assuming that the client's worries and her tendency to be other-focused is a detriment or an issue of resistance for treatment, use the client's concerns as a means of motivation throughout treatment.

### *Figure 2-6*
### *Primary Substance of Abuse Among Women Admitted for Substance Abuse Treatment by Racial/Ethnic Group by Percentage*

| Substance of Abuse | Caucasian | African American | Hispanic (Mexican Origin) | Hispanic (Puerto Rican Origin) | American Indian/ Alaska Native | Asian/ Pacific Islander | TWO OR MORE RACES |
|---|---|---|---|---|---|---|---|
| Alcohol | 35.5 | 24.8 | 22.6 | 20.4 | 39.5 | 26.4 | 21.7 |
| Cocaine/crack | 13.3 | 35.0 | 12.0 | 18.4 | 8.0 | 9.2 | 12.0 |
| Heroin | 12.7 | 16.3 | 11.8 | 38.5 | 9.7 | 8.2 | 5.7 |
| Other opioids | 7.7 | 1.3 | 1.7 | 1.8 | 4.7 | 3.1 | 4.0 |
| Marijuana/hashish | 11.8 | 17.6 | 15.6 | 15.2 | 10.2 | 16.3 | 19.4 |
| Methamphetamines | 13.3 | 1.7 | 34.0 | 2.2 | 25.2 | 33.1 | 31.9 |
| Benzodiazepines | 1.0 | 0.2 | 0.1 | 0.4 | 0.4 | 0.3 | 0.6 |
| Other amphetamines | 0.6 | 0.1 | 0.3 | 0.1 | 0.5 | 0.7 | 0.8 |
| Other sedatives/ hypnotics | 0.4 | 0.1 | 0.3 | 0.1 | 0.2 | 0.1 | 0.2 |
| Hallucinogens | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.2 | 0.1 |
| PCP | 0.0* | 0.4 | 0.5 | 0.3 | 0.1 | 0.2 | 0.2 |
| Inhalants | 0.1 | 0.1 | 0.2 | 0.0* | 0.2 | 0.1 | 0.2 |
| Over-the-counter (OTC) medications | 0.1 | 0.0* | 0.1 | 0.0* | 0.1 | 0.1 | 0.1 |

* Less than 0.05 percent

*Source:* HHS, SAMHSA, OAS 2008.

## *Advice to Clinicians and Administrators:* Using Patterns of Use as a Clinical Guide

### For Clinicians:

- Foremost, it is important to remember that women are as likely as men to become addicted to alcohol and drugs if given an opportunity. By making an assumption that women are less likely to have a substance use disorder, important information may not be obtained in the screening and assessment process, thus leading to misdiagnosis or under diagnosis.
- Depending on the specific drug class, some women may have considerable concerns regarding potential weight gain if they enter treatment and establish abstinence. Among women, weight loss is more likely a major benefit in continuing drug use.
- In assessing risk factors or potential triggers for relapse, don't underestimate that the initial reasons for use may be the same reasons for relapse, even if initial use occurred many years ago. As a clinician, it is important to prepare for a premature termination of treatment and establish an intervention plan tailored to address these initial reasons for use. More times than not, women generally will underestimate the risks associated with these issues. For example, women who initiated use due to a relationship will often deny that relationships are a current risk factor. Nonetheless, the counselor should not immediately follow the client's self-assessment but rather proceed with creating roleplays that simulate possible scenarios to provide practice in how to handle relationship issues before they actually occur in treatment; i.e., roleplay a telephone call from a boyfriend who believes that the client does not have a problem and begs her to come home. More often than not, other women in the treatment group have a better handle on the actual scenarios that are high risk for each other.
- Remember that women are socialized to be other-focused. Just because they may not have attended to some of their responsibilities during active substance use does not mean that they will not be focused on these responsibilities upon entering treatment. Rather than pushing the idea that they need to "get their head into treatment and not be so focused on outside issues," use their ability to be other-focused as a tool in developing motivation for recovery. Assuming that a woman is resistant to treatment because she is other-focused in the program is a form of gender bias. Women are socialized to think about others.
- Because substance abuse tends to run in families, a woman's parents and children as well as her partner need to be considered in planning treatment. As important, a woman needs to be aware of the influence of substance abuse in her family. Using a family geneogram or family tree to mark who has used substances can be a valuable tool in assessing the degree of influence in her family.
- A partner's substance use and attitudes toward substance use can influence a woman's substance use. A woman who uses illicit drugs is more likely to have a partner who also uses illicit drugs. The counselor should work with all individuals who have influence on the client so that each person develops attitudes and behaviors that will be supportive of the client's recovery.
- Remember to assess for personality traits that are more conducive to substance abuse among women, namely sensation-seeking.

## *Advice to Clinicians and Administrators:*
## Using Patterns of Use as a Clinical Guide (continued)

- Trauma is both a risk factor for and a consequence of substance abuse. Women with histories of trauma may be using substances to self-medicate symptoms. Subsequently, interventions should be immediately put into place to help build coping strategies to manage strong affect, including relaxation training and other anxiety management skills. Start skills-building immediately rather than waiting for an incident to occur. It is far more difficult to manage symptoms when they are heightened than when they are at lower levels of intensity.
- From the outset, counselors need to be aware of the potential and common occurrence and impact of co-occurring disorders among women with substance use disorders, especially mood, anxiety, and eating disorders.

### For Administrators:

- Administrators need to develop and incorporate policies and procedures that support family involvement from the onset. Beginning with the initial contact, staff need to convey the importance of family involvement and the program's expectations regarding the necessity of family participation.
- Adminstrators need to develop policies and procedures to address co-occurring issues, including screening, assessment, and referral processes. They need to secure funding and endorse programs that are effective with various populations, such as trauma-informed services and culturally responsive programs.

# Appendix A: Bibliography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