

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

**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

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Acknowledgments

This publication was prepared under contract numbers 270-99-7072 and 270-04-7049 by the Knowledge Application Program (KAP), a Joint Venture of The CDM Group, Inc., and JBS International, Inc., for the Substance Abuse and Mental Health Services Administration

(SAMHSA), U.S. Department of Health and Hu­ man Services (HHS). Andrea Kopstein, Ph.D., M.P.H., Karl D. White, Ed.D., and Christina Currier served as the Contracting Officer's Rep­ resentatives.

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Recommended Citation

Substance Almse and Mental Health Services Administration. *Substance Abuse Treatment: Addressing the Specific Needs of Women.* Treat­ ment Improvement Protocol (TIP) Series, No.

51. HHS Publication No. (SMA) 13-4426. Rock­ ville, **MD:** Substance Abuse and Mental Health Services Administration, 2009.

Originating Office

Quality Improvement and Workforce Develop­ ment Branch, Division of Services Improve­ ment, Center for Substance Abuse Treatment, Substance Almse and Mental Health Services Administration, 1 Choke Cherry Road, Rock­ ville, MD 20857.

HHS Publication No. (SMA) 13-4426 First Printed 2009

Revised 2010, 2012, and 2013

Electronic Access and Copies of Publication

This publication may be ordered from or downloaded from SAMHSA's Publications Ordering Web page at [http://store.samhsa.gov.](http://store.samhsa.gov/) Or, please call SAMHSA at 1-877-SAMHSA-7 (1-877-726-4727) (English and Espanol).

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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**

# 7 Substance Abuse Treatment for Women

#### Overview

**In This Chapter**

Treatment Retention

Women's Treatment Issues and Needs

Addressing Tobacco Use With Women

in Treatment

While women are as likely to stay and engage in treatment as men, substance abuse counselors need to attend to individual, counselor, and environmental variables to secure the best retention rates based on level of care and presenting problems. This chapter begins with gender-specific factors that significantly influence treatment retention of women. Other highlights include women's treatment issues and needs (beginning with the role of relationships-including family and partners), parenting issues and treatment needs (including pregnancy and children), and several co-occurring disorders (including anxiety, mood, and eating disorders) that are most prevalent among women and are likely to require attention during the course of treatment.

Significant consideration is also given to trauma, trauma-informed services, and integrated treatment for women with trauma-related symptoms and substance use disorders.

#### Treatment Retention

The many factors that influence clients to enter treatment are often the same ones that keep them in treatment. Treatment retention refers to the quantity or amount of treatment received by a client. Today, retention is more likely defined using the term "length of stay," and

is measured by months or a timeframe rather than by the number of sessions (Comfort and Kaltenbach 2000; Greenfield et al. 2007a). His­ torically, literature has reflected that treatment duration (retention) has served as one of the most consistent predictors of posttreatment outcome, yet literature remains limited regarding the specific relation­ ship between retention and outcome among women with substance use disorders. (For literature reviews on retention and outcome factors for women with substance use disorders, see Sun 2006; Greenfield et al. 2007a.)

Gender is not likely to predict retention in substance abuse treatment. For some time, it has been assumed that women are more likely to leave treatment, but some literature counters

this view (Joe et al. 1999). Do women have lower retention rates than men? This is a difficult question to answer because treatment retention often involves the contribution and interaction of numerous variables. Studies have begun to identify these variables and how they relate

to each other to influence treatment retention rates among women (see Ashley et al. 2004), but further research is needed to understand the complexity and interactions of these variables.

Psychiatric symptoms, drugs of choice, motivation levels, class, race, ethnicity, criminal justice history, addiction severity, and patterns of use are common factors that typically influence or predict retention among clients in general (see Simpson 1997). Among

women, several factors have been identified that influence or predict retention. The following section highlights these factors. Nonetheless, this is not an exhaustive list of retention conditions or issues, but one that is limited to factors

that are evident across several studies or that provide some insight into women's issues that need further empirical exploration.

###### Factors That Influence Retention Among Women

*Sociodemographics*

*Relationships:* Support from a partner during treatment and recovery can contribute significantly to long-term maintenance of

abstinence. Some treatment studies suggest that including a partner or significant other in a client's treatment also contributes significantly to successful short-term outcomes (Price and Simmel 2002). For example, couples therapy for women in alcohol and drug abuse treatment contributed to favorable outcomes in one study (Trepper et al. 2000), and a study by Fals­ Stewart and colleagues (2005) indicates that behavioral couples therapy was associated with abstinence and sustained recovery. Zlotnick

and colleagues (1996) also found family therapy to be an effective component for women in an outpatient substance abuse treatment program.

It appears that women who develop relationships in treatment are less likely to successfully complete treatment if their

new partner discontinues treatment. In one qualitative study, all of the women who did not successfully complete treatment established a sexual relationship during the early phase of outpatient treatment (Ravndal and Vaglum 1994).

*Age:* Age appears to be a factor that influences retention. According to the Drug Abuse Treatment Outcome Study (DATOS), age has a significant positive effect on retention in residential treatment (Grella et al. 2000). In

a study examining variables associated with retention in outpatient services, women younger than 21 were not as likely to successfully complete outpatient treatment (Scott-Lennox

et al. 2000). Likewise, criminal justice research found that women who are older at their first arrest were more likely to complete treatment (Pelissier 2004).

*Education:* Women with a high school education are more likely to stay in treatment. According to two studies (Ashley et al. 2004; Knight

et al. 2001), women who have a high school degree or equivalent are more likely to stay in treatment longer and complete treatment than women with less than a high school education. While education level is influential, it may be a reflection of other client characteristics or socioeconomic conditions.

*Women of color:* Research typically reflects lower retention rates among women of color. While more research is needed to pinpoint the specific factors that lead to lower retention rates among ethnically diverse women, a key variable appears to be economic resources. According

to Jacobson, Robinson, and Bluthenthal (2007), limited economic resources may play a more significant role in retention than specific demographics or severity of substance use disorder.

*Criminal justice and child* protective services referral and involvement

It appears that either referral or involvement

with the criminal justice system or child protective services is associated with longer lengths of treatment (Brady and Ashley 2005; Chen et al. 2004; Green et al. 2002). Specifically, Nishimoto and Roberts (2001) concluded **that** women who were mandated by the criminal justice system to enter treatment and who also had custody of their children were more likely

to stay in treatment longer. While some studies reflect mixed results on the effect of women being mandated to treatment by the court, another study (generated from the sample of participants in the Substance Abuse and Mental Health Services Administration's [SAMHSA's] Women, Co-Occurring Disorders, and Violence Study) found that retention was higher among women who had been mandated to treatment (Amaro et al. 2007).

*Pregnancy*

Pregnancy status can significantly influence treatment engagement and retention. Grella (1999) concluded that pregnant women were more likely to spend less time in treatment, and that pregnancy interrupted treatment. Yet, the length of stay may be more related to the stage of pregnancy. **In** another retention study among women, women who entered treatment late **in** their pregnancies had good retention whereas women who entered treatment in their first trimester tended to leave treatment early (Chen et al. 2004).

*Pregnancy and co-occurring disorders:* Pregnancy often adds to the challenge of retaining clients who have severe psychiatric disorders **in** treatment. In one study **(Haller** et al. 2002) that compared retention rates across three groups of women, the group characterized by severe addiction, psychiatric (DSM Axis 1 diagnosis) and personality (DSM Axis 2 diagnosis) disorders had rapid attrition (a 36 percent dropout rate), whereas the groups described as clinically benign or with

less severity but with externalizing personality

deficits were more likely to complete treatment. In a similar study conducted by Haller and Miles (2004), women with more severe pathology were twice as likely to leave treatment against medical advice. While these studies have limitations, they do shed light on the role of psychiatric issues in retention among women, particularly pregnant women, and the need to provide appropriate intervention earlier in the treatment process. The findings of a study examining the effects of trauma-integrated services suggest that women who receive these mental health services may engage in treatment longer (Amaro et al.

2008).

*Treatment environment and* theoretical approach

*Supportive therapy:* The consensus panel's

clinical experience has shown that women who abuse substances benefit more from supportive therapies than from other types of therapeutic approaches. Review of the literature indicates that positive treatment outcomes for women are associated with variables related to the characteristics of the therapist (e.g., warmth, empathy, the ability to stay connected during treatment crises, and the ability to manage

countertransference during therapy; Beutler et al. 1994; Cramer 2002; Crits-Christoph et al.

1991). Women need a treatment environment that is supportive, safe, and nurturing (Cohen 2000; Grosenick and Hatmaker 2000; Finkelstein et al. 1997); the therapeutic relationship should be one of mutual respect, empathy, and compassion (Covington 2002b).

The type of confrontation used in traditional programs tends to be ineffective for women unless a trusting, therapeutic relationship has been developed (Drabble 1996). Early research on women in treatment demonstrated that women entered treatment with lower self-esteem than their male counterparts (Beckman 1994). Hence, the traditional practice during recovery of "breaking down" a person who abuses substances and rebuilding her as a person is considered unduly harsh and not conducive

to effecting change among women who abuse substances (Covington 2008a rev., 1999a; Drabble 1996; Kasi 1992). Although designed

to break through a client's denial, these approaches can diminish a woman's self-esteem further and, in some cases, retraumatize her. Approaches based on awareness, understanding, and trust are less aggressive and more likely to effect change (Miller and Rollnick 2002). An atmosphere of acceptance, hope, and support creates the foundation women need to work through challenges productively.

*Collaborative approach:* Leading practitioners in the field of substance abuse treatment for women suggest that effective therapeutic styles are best characterized as active, constructive, collaboratively and productively challenging, supportive, and optimistic (Covington and Surrey 1997; Finkelstein 1993, 1996; Miller

and Rollnick 1991). Effective therapeutic styles focus on treatment goals that are important to the client. This may mean addressing issues of food, housing, or transportation first. Having her primary needs met builds a woman's trust and allows her to address her substance use. A collaborative, supportive approach builds on the client's strengths, encourages her to use her strengths, and increases her confidence in her ability to identify and resolve problems.

Effective therapeutic styles facilitate the client's awareness of the difference between the way her life is now and the way she wants it to be. The client and counselor agree to work together to identify the client's distortions in thinking­ discrepancies between what is important

to her and how her behavior and coping mechanisms prevent her from reaching her goals. Approaching treatment as a collaboration between equal partners-where the therapist

is the expert on what has helped other people

and the client is the expert on what will work for herself-may reduce the client's resistance to change.

*Type of treatment services*

*Same-sex versus mix-gender groups:* While literature (Grella 1999; Gutierres and Todd 1997; Niv and Hser 2007; Roberts and Nishimoto 1996; Zilberman et al. 2003) generally supports same-sex groups as being more beneficial than mix-gender groups for women, most research surrounding this issue is either too small to generalize, fails to control for

other factors that mayinfluence results, or falls short in matching and evaluating same-sex and mix-gender groups using comparable services and program lengths. Inconsistent results are evident when comparing retention and outcome rates between both groups (Kaskutas et al.

2005). Historically, research has not controlled for the confounding variable that female-only groups provide more gender-responsive services than mix-gender groups. These enhanced services may be more responsible for retention and outcome than the gender constellation of treatment. In one study comparing women in

a female-only program to a mix-gender group, the author concluded that just placing women in a same-sex group without women-specific treatment services is not effective in improving retention or outcome (Bride 2001).

More rigorous studies are needed to clarify factors. Several qualitative studies (Grosenick and Hatmaker 2000; Nelson-Zlupko et al. 1996; Ravndal and Vaglum 1994) have highlighted that women perceive same-sex or female-only groups as more beneficial than mix-gender groups

While women may perceive female-only groups as beneficial, it is important for clinicians to prepare for and recognize that some women may express hostility toward other women in the group or treatment program. Women are as likely to impose the same societal gender stereotypes that they experience onto other women in the group (Cowan and Ullman 2006). Some women may see other women as a threat to their relationships and engage in competitive behavior in the group process, and other women may impose and project their internalized negative stereotypes onto other group members; e.g., blaming a woman who was victimized by violence or making assumptions about, calling attention to, or labeling another woman's sexual behavior.

***Note to Clinicians***

because they provide the women more freedom to talk about difficult topics such as abuse and relationship issues and to focus on themselves rather than on the menin the group. TIP 41 *Substance Abuse Treatment: Group Therapy* (CSAT 2005d), provides more information

on treatment issues and process using group therapy.

*Service delivery:* Women who have access

to various services in one location appear to have higher retention rates (McMurtrie et al. 1999; Volpicelli et al. 2000). In addition,

studies support that women who are involved in or initially receive greater intensive care, specifically residential treatment, are more likely to remain in treatment and in continuing care (Coughey et al. 1998; Strantz and Welch 1995). Retention is also heightened when treatment services also include individual counseling for women (Nelson-Zlupko et al.

1996).

*Onsite child care and child services:* In two randomized studies (Hughes et al. 1995;

Stevens and Patton 1998) comparing women in residential programs whose children stayed **with** them versus women whose children did not stay with them, women whose children stayed with them had a longer length of stay (retention).

Other less rigorous studies provide similar results (Ashley et al. 2004; Metsch et al. 2001; Nelson-Zlupko et al. 1996; Wobie et al. 1997). For more information on children in residential treatment programs, see chapter 5, "Treatment Engagement, Placement, and Planning."

*Therapeutic alliance and counselor* characteristics

Although the relationship with the counselor is

important to both men and women, each gender defines this connection differently. When women and men were asked what was important about the quality of their therapeutic relationships and their recovery from substance abuse, most women answered trust and warmth, and most men answered a utilitarian problemsolving approach (Fiorentine and Anglin 1997). Across studies, women have identified several counselor characteristics they believe contribute to treatment success: non-authoritarian attitudes and approach, confidence and faith in their abilities, and projection of acceptance and care (Sun 2006). Overall, the therapeutic alliance appears to play a paramount role in predicting posttreatment outcome (Gehart and Lyle 2001; Joe et al. 2001; Miller et al. 1997).

*Staff gender:* Research on the impact of gender differences in client-counselor relationships is limited across mental health professions and

is nearly non-existent in the substance abuse field. Although women show greater preference for female staff in addiction treatment,

further research is needed in examining the role of gender in treatment retention and outcome among women in individual versus group counseling, same-sex versus mix-gender groups and treatment programs, and women at

different levels of substance abuse treatment. In a study that examined how clients in inpatient substance abuse treatment would view their ideal male and female counselor, gender was

not considered an important variable even

"Men may need to pay particular attention to certain issues when counseling women. The issues of anger, autonomy, power, and stereotypical roles have great impact on women clients and

are extremely important issues for women in therapy. For some women, because of previous dependence on men, their emotional responses to anger are more likely to be repressed and viewed as unacceptable. For other women, autonomy and power are often seen as masculine traits and inappropriate for women. Men's greater, or perhaps different, familiarity with anger, autonomy, and power can potentially provide therapeutic benefit for their women clients" (DeVoe 1990, p. 33).

***Implications for the Male Counselor***

Programs that maintain relationships or connections with women throughout their treatment and during step-down transitions from more intensive to less intensive treatment appear paramount in maintaining high levels of retention. Using supportive telephone calls between residential and outpatient addiction treatment is an effective strategy for women. Women are more likely than men to attend continuing care if a telephone intervention is implemented (Carter et al. 2008). In addition, women are more likely to stay in treatment during transitions to less intensive levels of care if it is the same treatment agency (Scott-Lennox et al. 2000).

***Improving Transitions and Retention Rates for Women***

though the majority of clients preferred a female therapist (Jonker et al. 2000). Prior research on therapist preference in counseling highlighted that nearly 95 percent of women who expressed a preference specified a female counselor (Stamler et al. 1991). Grosenick and Hatmaker (2000) reported that 82 percent of the women and treatment staff in a residential program treating pregnant women and women with children believed it was important to have female staff, while 38 percent of the clients and

46 percent of the staff sample asserted that male staff were important. For those who endorsed the importance of male staff, they indicated that menserve as male role models for children and provide a male perspective on various clinical issues, such as relationships.

In a study that examined the influence of both client-counselor race and gender composition in treatment retention among African-American clients in intensive outpatient groups (Sterling

et al. 1998), no significant gender differences were found. Nonetheless, several trends were evident. Female clients treated by female counselors stayed in treatment 5 days longer than mix-matched gender groups (mix-matched refers to clients being matched to counselors

of the opposite sex), and women in gender­ matched groups at discharge were more likely to continue outpatient care. The authors suggested that different results may have transpired if they had examined the role of gender and race in client-counselor relationships in individual substance abuse counseling versus group therapy. Research focused specifically on

client-counselor race and gender composition in women's treatment is lacking.

*Client's confidence in the process*

A woman's successful experience **in** other life areas and her level of confidence in the

treatment process appear important to staying in treatment. Kelly, Blacksin, and Mason (2001) compared two groups of women-a group that completed treatment and another group that did not-to ascertain factors affecting substance abuse treatment completion. They found that women who had prior successes were more apt to complete treatment. While self-efficacy may play an important role, methodological issues and other factors may be as responsible for the study's results, namely the limited economic resources in the group of non-completers. In addition, other general retention studies have highlighted the importance of the therapist's prognosis of client retention; thus the counselor's confidence may be as significant to retention as the client's confidence (Cournoyer et al. 2007). Further gender-specific retention research is needed to address the role of self­ confidence and confidence in the treatment process.

Theoretical Approaches for Women

In a meta-analysis of studies on treatment approaches, Wampold (2001) attributed more than half of the effect of therapies to therapeutic alliance-a keyelement of all the

theoretical approaches. Some approaches have significant clinical and empirical support in substance abuse treatment research literature (including motivational interviewing, cognitive­ behavioral therapies, and some psychodynamic

approaches), however, research highlighting the role of gender differences is in its infancy, and limited research is available that delineates gender-specific factors that contribute to the effectiveness of these therapies. Data available at the time of publication is referenced throughout this TIP. For general information on counseling theories, refer to TIP 34 *Brief*

*Interventions and Brief Therapies for Substance Abuse* (CSAT 1999a); TIP 35 *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999b); and TIP 47 *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment* (provides an overview of counseling theories; CSAT 2006c).

#### Women's Treatment Issues and Needs

Relationships and the Need for Connection

Relationships are central in women's lives-as part of their identities, as sources of self-esteem, as the context for decisionmaking and choices, and as support for day-to-day living and growth (Covington and Surrey 1997; Finkelstein

1993, 1996; Miller 1984). Connections are relationships that are healthy and supportive­ mutual, empowering, and emotional resources. "Disconnections" involve relationships that

are not mutual and empowering: one member is dominant, there is imbalance in the give and take, or a disparity exists in emotional supportiveness. Disconnections range from feeling "unheard" or "unknown" to extreme forms of disconnection, such as sexual abuse and violence. Disconnections create major difficulties for most women, such as lowered

self-esteem, feelings of powerlessness, and lack of assertiveness. The experience of relationships as connections and disconnections is a central issue in personality development, with repeated severe disconnections potentially having serious psychological and behavioral consequences.

The Influence of Family

Treatment providers should be sensitive to the relational history women bring into treatment, both positive and negative. For instance, the extended family often functions as a safety net that provides women with child care, financial support, and emotional and spiritual guidance (Balcazar and Qian 2000). However, few studies have examined the role of the extended family in the development of substance abuse and recovery. While research on the extended family tends to define its role as primarily protective, drinking and drug use in the family can contribute to the development of abuse.

Many women who abuse substances were raised in families where there was chemical abuse, sexual abuse, violence, and other relational disconnections. These family relationships form a basic model for the relationships women later develop with others.

Women with a substance-using family background may develop adult relationships that mimic these broken family dynamics. Thus many women who have family members who used substances also may have a partner or friend who abuses substances. Relationships that center on substance use, or include emotionally or physically negative, harmful behavior (whether past or present), can play a significant role in enabling a woman's continuing substance use.

To assess the impact of a client's family relationships, treatment providers should explore the role of the extended family in her life and try to determine how her substance abuse has affected her relationships with family members. Counselors should also help a client to explore her current relationships outside

her family in the light of her substance use. Counselors may need to work with some clients to help them understand the negative effects these relationships can have.

In addition, skills related to improving the quality of relationships-such as communication, stress management, assertiveness, problemsolving,

and parenting-can be an important part of treatment. To help clients learn these skills,

treatment providers can model connection with clients, provide support, help clients repair or replace hurtful or damaging relationships, and help clients "redefine" their families (Knight et al. 2001b). Family therapy is a more essential approach in substance abuse treatment for women. For more guidance in employing family therapy, refer to TIP 39 *Substance Abuse Treatment and Family Therapy* (CSAT 2004b).

If maintaining or reconnecting with extended family members is not an option, plans should be made to find alternatives in developing

a support system or a "family of choice." However, the grief associated with the loss of the original family needs to be addressed. Treatment programs can help women connect with natural supports in the community-friends, work colleagues, and significant others (Knight and Simpson 1996). Developing or maintaining

***Advice to Clinicians:***

###### Relational Model Approach

Beginning in the 1970s, a number of theorists started to examine the importance of gender differences in psychological development. Jean Baker Miller's Toward a New Psychology of Women (1976) offered a new perspective on the psychology of

women that challenged the basic assumptions of traditional theories. Carol Gilligan, a developmental psychologist, gathered empirical data on fundamental gender differences in the psychological and moral development of women and men (Gilligan 1982).

Drawing on Miller's and Gilligan's work, theorists have been developing a relational model of women's psychology. The three major themes in relational theory are:

* *Cultural context.* Recognizes the powerful effect of the cultural context on women's lives.
* *Relationships.* Stresses relationships as the central organizing feature in women's development. Traditional developmental models of growth emphasize independence and autonomy. This model focuses on women's connection with others.
* *Pathways to growth.* Acknowledges women's relational qualities and activities as

potential strengths that provide pathways to healthy growth and development.

The relational-cultural theory affirms the power of connection and the pain of disconnection for women, with repeated disconnections having adverse consequences for mental health (Covington and Surrey 1997; Jordon and Hartling 2002). As a result, the approach requires a paradigm shift that has led to a reframing of key concepts in

psychological development, theory, and practice. For example, instead of using the "self" as the sole focus, the model focuses on relational development.

According to Miller, "Women's sense of self becomes very much organized around being able to make and then to maintain affiliations and relationships" (Miller 1984, p. 83).

More than men, women find an activity more satisfying and more pleasurable when others are involved. Therefore, for women, relationships directly affect their feelings of empowerment, self-worth, and self-esteem.

Substance abuse treatment often provides a woman her first opportunity to establish new, healthy relationships-especially relationships with other women. Accordingly, counselors should help women to "examine past relationships, including issues of loss, violence, and incest; to validate and build upon [their] relational skills and needs; to learn how to parent successfully; ... to let go of problematic, abusive relationships" (Finkelstein 1996, p. 28); and to confront the loss of a primary relationship with their drug of abuse (Cramer 2002).

positive relationships can improve women's self­ esteem and increase their feelings of self-efficacy (Finkelstein et al. 1997). Further, a high degree of social support is positively related to better treatment outcomes (Laudet et al. 1999).

Partner Relationships

Many women drink and use substances to maintain relationships and cope with the pain and trauma of lost relationships. Some women feel they are expected to maintain relationships at all costs, even if those relationships are undermining, abusive, or otherwise detrimental. Women may stay in harmful relationships because of economic or social dependence.

Treatment providers sometimes unknowingly reinforce this expectation by focusing on the importance of relationships to the exclusion of helping their clients increase their feelings of autonomy, healthy solitude, and individuality­ also important needs for women.

Once a woman's significant relationships have been examined relative to her substance use, the counselor and client can work together on a plan for reconnecting with significant others during recovery (if possible). Yet, engaging a partner

in a woman's treatment can be challenging, especially in balancing issues of the woman's and her partner's needs, safety concerns, and lack

of funding for partner and family services. Few models within women's treatment programs exist that include partners and other family members, and even fewer address lesbian partners. Price and Simmel (2002) provide an overview of the issues surrounding a partner's influence on a woman's addiction and recovery and examples of model programs. They recommend starting with a thorough assessment after a woman has identified her partner(s) and given permission to involve the partner in treatment.

As women become healthy through participating in treatment and developing appropriate relationships, and as other supports (e.g., financial, housing) are put in place, it is hoped they will choose to reevaluate relationships

that are detrimental to their well-being and recovery. When women decide to end significant relationships, counselors should realize that

ending these significant relationships is a real loss that must be mourned while new

attachments are being created. However, some women often choose to continue to participate in, or may be unable to escape, destructive relationships.

Tolerating or accepting a client's relationships that the counselor finds objectionable is complicated because a woman's substance abuse frequently is maintained in connection with

her partner (Amaro and Hardy-Fanta 1995), and maintaining this relationship can increase her risk of relapse. Thus, any relationship that enables a woman to continue to abuse substances or threatens her safety becomes a therapeutic issue between a counselor and a female client.

The counselor should acknowledge a woman's feelings about that relationship, regardless of the counselor's opinion about what is best for the client. However, if a client is in danger of being victimized, the counselor should primarily be focused on ensuring her safety. Initially, staff should take immediate measures to increase physical safety in the treatment environment­ in both outpatient and inpatient settings.

In addition to validating her experience, it is important to help facilitate a safety plan that maynecessitate additional referrals to domestic violence hotlines and shelters. To review a sample personalized safety plan for

domestic violence, refer to Appendix Din TIP 25 *Substance Abuse Treatment and Domestic Violence* (CSAT 1997b).

Safety issues for the client or her children may preclude the partner's involvement. If the client does not feel safe involving her partner, the emphasis should change to safety planning.

Several curricula focus on a woman's relationships in recovery and help her identify, assess, and evaluate both destructive and empowering relationships and support systems. Covington's curriculum, *Helping Women Recover* (2008a, 1999a), allows women to examine their relationships and support systems. Najavits' *Seeking Safety* (2002a) and *Womans Addiction Workbook* (2002) include

information that assists women in understanding healthy and unhealthy boundaries, strategies

***Advice to Clinicians:***

###### Considerations in Involving the Partner in Treatment

In deciding whether or not to involve a woman's partner in treatment, primary consideration should be given to her safety and to the partner's willingness to participate in treatment. The following important issues should also be assessed

to determine participation and level of treatment involvement and to establish an appropriate treatment plan:

* **History of violence:** Has there been a history of violence in the relationship, including threats and other emotional, physical, and/or sexual abuse; protection orders; police reports; or citations for domestic violence or assaults? Is there a history of impulsivity with client or partner? Has there been a history of violence outside the relationship, in previous relationships, or with children? Is there a recognizable progression of violence in the relationship?
* **History of substance use in the relationship:** How influential has this partner been regarding the client's continued drug and alcohol use? Does the partner see the woman's alcohol and/or drug use as a problem needing treatment? Has the history of the relationship been centered upon using or providing drugs and alcohol? How often are alcohol and other drugs used when engaged in activities with each other or during sexual intimacy? Is the client or partner worried about having sex

without being under the influence of substances? Has the client left prior treatment experiences prematurely due to this relationship? Is the client worried that her partner is going to leave either as a result of her use or of her treatment? Does the client acknowledge that her use has impacted the relationship? Is she able to describe how her substance use has affected the relationship?

* **Partner's history of substance use:** What is the partner's attitude toward alcohol and drug use? Does he/she use as well? Is he/she in recovery? Has the partner been arrested, charged, or convicted of alcohol or drug related offenses? Does the client minimize the influence of her partner's current drug and alcohol use?
* **Accessibility:** Does the partner have the financial resources and transportation to attend treatment? Are there potential barriers that limit physical attendance, such as distance from program, transportation, work schedule, financial resources, childcare responsibilities?
* **History of mental illness:** Are there any known mental health issues with the partner or client that have or will impact the relationship?
* **Relationship support of the partner:** Has the partner been emotionally supportive throughout the history of the relationship? Currently, how emotionally supportive is the partner regarding the client's treatment and recovery? Does the partner play an essential role in childcare? Does the partner provide financial support? Has the

partner ever threatened to leave, withdraw financial support, or threaten the custody of the children?

* **Commitment to relationship:** Is there a current commitment to maintaining the relationship?

Safety issues for the client or her children may preclude the partner's involvement. If the client does not feel safe involving her partner, the emphasis should change to safety planning.

***Note to Clinicians***

for identifying persons who can be positive (supportive) or negative (destructive) influences on their recovery, tactics for enhancing or minimizing those influences, and activities to enhance support from other women. Cohen's *Counseling Addicted Women: A Practical Guide* (2000) provides client and staff activities surrounding relationship issues.

###### Sexuality

Healthy sexuality is integral to one's sense of self-worth. Sexuality represents the integration of

biological, emotional, social, and spiritual aspects of who one is and how one relates to others. If healthy sexuality is defined as the integration

of all these aspects of the self, it is apparent how substance abuse can have an impact on every area of a woman's sexuality. In addition,

sexuality is one of the primary areas that women say change the most between substance abuse or dependence and recovery and is a major trigger for relapse (Covington 2008a, 1999a, 2007).

Women and men are socialized into different gender roles. For example, many men are taught to seem knowledgeable about sex and be comfortable with their bodies. In contrast, women struggle more with body image and are socialized to be less assertive sexually or risk

being labeled as promiscuous. This polarization of sex roles is mirrored in society's belief about male and female substance use. Women who use substances are perceived as being more eager for sex and more vulnerable to seduction (George et al. 1988). This is reflected in the stronger stigma against women with substance use disorders, which is often expressed in sexual terms and labels women as promiscuous or sexually loose. Sexual terms are rarely used to describe men with substance use disorders.

Recovery and healing goes beyond abstinence from alcohol or drugs to developing relationships with others. Many women will need

to explore the connections between substance abuse and sexuality, body image, sexual identity, sexual abuse, and the fear of sex when they are alcohol and drug free. Therefore, the consensus panel believes that discussion of women's

sexual issues is an important part of substance abuse treatment. The following are some of the sexual concerns that women report during early recovery:

* *Sexual identity.* Counselors may need to help a woman determine her sexual identity as a heterosexual, lesbian, or bisexual person. Substance abuse during adolescence can interrupt the healthy development

of sexual identity. Circumstances such as prostitution or incarceration may lead women to participate in sexual activity with other women. Some women use drugs to suppress their sexual feelings toward other women. Others use drugs to act on their erotic attachment to other women and may feel confused about their sexual identity when in recovery. Once the substance of abuse has been removed from a woman's life, the counselor can help her discover whether her identity is heterosexual, lesbian, or bisexual (Covington 1997). For review of sexual identity stages of development and

its relationship to substance abuse, see *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals* (CSAT 2001b, pp. 61-67).

* *Fear of sex while abstinent.* Many women enter treatment with little or no experience of sexual relationships without being under the influence of substances. For women with a history of sexual trauma, using alcohol and drugs to manage emotions while having sex may have served as an important coping mechanism. Subsequently, women may become fearful of having sex without the assistance of substances (Covington 2000,

***Clinical Activity: Exploring the History and Influence of Relationships: Sociogram***

Using a simple diagram (referred to as a sociogram) that was pioneered by J. L. Moreno in the 1940s, clients can highlight their most influential female and/or male relationships (including positive and negative attributes). Starting with this diagram, counselors can use this activity as a foundation to help women explore how these relationships influence current relationship

patterns, preference for male or female friends, attitudes toward other women and/or men, and the development of support systems.

Depending on your goal, you can have the client focus only on the men or women who have been most influential in their lives. Generally, the exercise provides more clarity for the client if you focus on only one gender at a time. Yet, your selection depends on your treatment goal, the

client's current struggles, and previous relationship history. If the woman is having a difficult time connecting with other women in treatment, it may he helpful to start with a history of her female relationships. Even though there are other ingredients that influence how a woman relates to

and views other women (namely gender socialization), a sociogram that begins with the history of female relationships may enhance awareness of the issues that impede her ability to relate to other women. At other times, it may he more fruitful to focus on the history of male relationships with women due to clinical issues that involve men. Here are directions and a sample of a sociogram on female relationships:

Provide the client with a piece of paper and a pencil, and ask her to list the most influential females throughout her life. The list should include women who have had the most significant impact-both positive and negative. It should not be limited to family members, hut instead include women throughout her lifespan up to the present day. The list should consist of women who have had a powerful influence even if the encounter was brief. You could ask her to limit the list to six to eight women for this exercise. She can always go hack and add individuals later on.

After compiling this list (it takes about 3 to 5 minutes), have the client turn the page over and draw a circle (about the size of a quarter) in the middle of the page and have her place her own name within the circle. Referring hack to her list of influential women, ask the client to draw a circle for each influential woman on the piece of paper and to place the circles in reference to how influential they have been in her life-placing the most influential women closer to her circle and other women with less influence farther away on the page. The circle can he placed anywhere on the paper. For example, if you have a client with a physically abusive mother and the client feels that this history prevented her from trusting other women, she may place the circle, labeled "Mother" quite close to her circle.

After instructing the client to draw and place the circles on the page so that the placement represents how influential or how much she believes this relationship affected her, ask the client to go hack and list three things in each circle that she learned about other women based on each specific relationship. For example, you may say to the client, "What did you learn about women based on your relationship with your mother and how your mother was with you? Select three things and write them in the circle that is labeled 'Mother."'

Upon completion, have the client present her sociogram. This exercise works quite well in a women's group and in individual counseling. In group, **it** promotes a dynamic discussion on how women learn to relate to each other, and it creates an opportunity to understand how each client's history of female relationships can influence current relationships in treatment and recovery. As a counselor, you can promote further discussion by asking the following questions:

*Clinical Activity:* Exploring the History and Influence of Relationships: Sociogram

***(continued)***

Are there any themes or recurrent patterns in this sociogram?

1. How does this history influence your relationship with other women in treatment, in therapy groups, and in support groups?
2. Can you provide a specific and recent example of how your history of relationships affected or contributed to a specific situation in treatment?

*Sample Sociogram Exercise: 11What have I learned from each*

***relationship about other women?"***

**High School**

**friend: Lenore** Kind, patient, undependable, will drop you for men

**Sponsor: Georgia** Steadfast, dependable, patient

**Current Girlfriend: Cheryl** Used drugs together, loyal, secretive, trustworthy

**Self**

**Sister:**

**Amy** Competitive, will steal your men, angry

**Mother:** Competitive, not dependable, cold

**Sister: Tara** Unavailable, secretive, angry

1997). Trauma survivors may view sex as taboo or hurtful and their sexual responses as bad. In addition, sexual relationships sometimes can trigger painful memories

of past abuse that can create difficulties for women, particularly in early recovery (Covington 1997; Finkelstein 1996).

* + *Sexual dysfunctions.* Alcohol and drugs interfere with sexual sensitivity and enjoyment in many ways. They disrupt the delicate balance of a woman's hormonal system, interfering with her body's emotional, reproductive, and physiological functions (Greenfield and O'Leary 2002). Women with substance use disorders have the same kinds of sexual dysfunctions as those without the disorder (lack of orgasm, lack

of lubrication, lack of sexual interest, etc.), but they have more problems more often (Covington 2000).

* + *Sexual and interpersonal violence.* Sexuality often is associated with violence and

abuse for female clients with histories of trauma. Consequently, they may be fearful, angry, and distrustful, and have difficulty functioning sexually. Given the association between substance abuse and sexual abuse (Ullman et al. 2005), women who have been abused may use alcohol or drugs to numb

the emotional pain of the abusive experience. This can create a spiraling relationship where many women use substances to alleviate the sexual difficulties they are experiencing.

But the alcohol or drugs only exacerbate the problem. Women who are under the influence of drugs are at greater risk for sexual and physical aggression (Blume 1991; Testa et al. 2003), and this remains true with pregnant women who have substance use disorders (Velez et al. 2006).

* + *Sexually transmitted diseases (STDs).* The use of alcohol and drugs increases the likelihood of contracting STDs, including

HIV/AIDS. There are three primary reasons for this increased risk. When drunk or high, many women neglect to protect themselves against STDs or to make sure they do not use contaminated needles (Evans et al. 2003; Pugatch et al. 2000). Often women with substance use disorders find themselves

in relationships with men who are also chemically dependent, thereby increasing the risk that their partner mayhave STDs or are **HIV** positive. In addition, rates of other infectious diseases among women with substance use disorders tend to be

higher than among other female populations (CSAT 1993c; Grella et al. 1995). Notably, preliminary findings suggest that women who inject illicit drugs and have sex with other women exhibit increased HIV infection and risk behaviors in comparison to other people who use injection drugs (Young et al. 2005).

In addition to research pertaining to prevalence, counselors need to address clinical issues associated with infectious diseases. Specifically, shame and stigma are highly associated with sexually transmitted diseases and HIV infection (Fortenberry et al. 2002), and, as a result, women who are addicted and infected with

a sexually transmitted disease are likely to perceive and experience a more profound sense of shame and higher levels of stigma­ potentially serving as a barrier to engaging in help-seeking behavior.

Pregnancy

Pregnancy creates stress for many women. Literature suggests that this stress can come from the woman's physical discomfort; her anxiety about the health of her fetus and how she will care for her baby; or her shame from the social stigma of using drugs, alcohol, or tobacco while she is pregnant (Daley et al.

1998). Providers can create an atmosphere that supports talking freely about pregnancy and recognize that ambivalence toward pregnancy is a normal reaction. Counselors should make

a careful assessment of the woman's existing parenting and other family responsibilities and of the social services and economic resources the mother needs.

Some women experience feelings of ambivalence about their pregnancy that become apparent during treatment. Educational programs, particularly for young women, that review

the effects of alcohol, drug, and tobacco use on pregnant women and their fetuses may

provide motivation to enter treatment, but this information will probably also generate concern over the status of their fetus. Counselors should be supportive of the client as she processes this emotionally difficult information. Counselors must understand a woman's guilt, shame,

and unspoken feelings about the effects of substance use on fetal health and development. Counselors can advocate for fetal well-being but must also give the mother information that is nonjudgmental. It is important for counselors to stress that "it is never too late to stop," and that whenever pregnant women reduce or stop drug and alcohol use, benefits are obtained!

Women should be encouraged to consult with an obstetrician or geneticist regarding their concerns of prenatal exposure on the fetus. However, caution should be exercised in evaluating pregnancy outcomes based on use of alcohol, drugs, or tobacco during pregnancy and their possible effects on the newborn. It is almost impossible to make accurate predictions on neonatal outcomes. Nevertheless, a woman should have support from her substance abuse counselor to meet with her prenatal care provider to discuss these issues.

After detoxification and stabilization, counselors should offer the important message that abstinence, staying in substance abuse treatment, and prenatal care can reduce the impact of substance use on the fetus (Bolnick and Rayburn 2003). Research indicates that

a positive environment is as enriching to a child's early growth and development as

prenatal exposure to substances is detrimental (Frank et al. 2001; **Hurt** et al. 2001). After the child is born, a mother can work to create a positive environment for her child's healthy development. This approach emphasizes the recovering woman's control and self-efficacy; it is another element of empowerment for recovering women (Covington 2002a).

###### Parenting

A woman's relationship with her children and her identity as a mother play a vital role in her sense of self. These relationships are important in recovery from substance use disorders. The

consensus panel believes that substance abuse treatment programs should offer treatment that addresses the critical component of parenting connections to children, as well as a full range of children's physical and mental health care, along with other services, whether within a treatment program itself, or by referral to a collaborating agency. Refer to chapter 5 for more specific information on programming across each level of care for women who are pregnant and/or have children.

Most mothers who are in substance abuse treatment feel a strong connection with their children and want to be good mothers. Most want to maintain or regain custody of their children and become "caring and competent parents" (Brudenell 2000, p. 86). Women who believe they have not cared for their children adequately or who believe that they are perceived as having neglected their children carry enormous guilt (Sun 2000). Therefore, for many women, maintaining caring relationships with their children is sufficient motivation to keep them in treatment. Unfortunately they often have inadequate role models in their own lives or lack the information, skills, or economic resources that could make motherhood less difficult (Camp and Finkelstein 1997; Moore and Finkelstein 2001). They also have the challenge of balancing the work necessary for recovery with their tasks as mothers. Another challenge treatment providers may face is the mother who is developmentally disabled to the extent that her mothering is inadequate. Ensuring the safety of her children while respecting the mother's choice to care for them requires careful case management to provide support for the mother.

People take from their family relationships a basic sense of their own identity and an equally basic model for the relationships they later develop with others. Mother-child relationships are understood to be the model for the child's future relationships. At the same time, because women tend to develop their sense of self through relationships, a woman's identity is also deepened when she becomes a mother.

Society places a high value on a woman's ability to mother, and her own perceived success or

failure in this endeavor forms an important aspect of her self-concept. For a mother with a substance use disorder, this concept can be paramount (Feinberg 1995).

*Parenting programs*

Research findings are inconsistent in demonstrating the effectiveness of behavioral parenting programs for improving the parent­ child relationship and children's psychological adjustment among mothers who have substance use disorders (for review, see Suchman et al.

2004; Suchman et al. 2007; Velez et al. 2004). More research is needed to evaluate the most effective parenting approaches and to address research methodological issues surrounding parenting program evaluations. In general, literature appears to support combining behavioral training with attachment-based parenting interventions (relational model).

A strengths-based relational approach to parenting assumes maternal assets already exist that can be identified and built on, and that the emotional quality of the parent-child relationship is equally important in improving the parent-child relationship and psychological

adjustment of the child. In essence, parenting is a relationship-not solely a set of skills. Some topics for parenting skills and relationship building include:

* + Age- and developmentally appropriate behavioral expectations for children.
  + Children's emotional, physical, and developmental needs.
  + Parenting styles and other childrearing practices, including attachment-oriented approaches (defined as enhancing the parent's ability to accurately perceive and sensitively respond to the emotional needs reflected in their child's behavior) (Slade and Cohen 1996; Suchman et al. 2006).
  + Strategies to improve nurturing that begin with helping mothers find a way to nurture themselves as an important step in learning how to nurture their children.
  + Constructive discipline strategies without corporal punishment.
* Anger management strategies to assist parents in learning how they can appropriately manage their strong feelings.
* Appropriate parent-child roles including modeling opportunities.
* Integration of culturally congruent parenting practices and expectations.

Clients need time to practice these new parenting skills and change patterns of behavior to improve interactions with their children (CSAT *2000b).* It is helpful to match parenting, coaching, or other support groups to the woman's ability to cope with her children and the other problems she is facing. Substance abuse counselors must simultaneously help mothers address their other ongoing challenges while teaching them to be better parents (Camp and Finkelstein 1997). Programs that provide support and parent training to mothers can

also help children by building their self-esteem, supporting them educationally and emotionally, and assisting them to achieve developmental milestones.

Children affected by maternal alcohol and drug dependence have increased vulnerability for physical, social-emotional, and academic problems (Conners et al. 2004; VanDeMark et al. 2005). Moreover, analysis from SAMHSA's Women, Co-Occurring Disorders and Violence

Study (WCDVS) suggests that children are also at an increased risk for physical child abuse when the mother has a current history of mental health symptoms, alcohol and drug use severity, and trauma (Rinehart et al. 2005). Thus, children need more than just adequate child care.

The consensus panel recommends that an onsite child specialist or one available by referral should be a standard element of programs that include children. Assessment and screening

for developmental and learning delays and social problems is necessary, as are play and expressive therapies that help children

acknowledge and express feelings about their parents' problems. Children should be provided with information regarding their mother's substance use disorder in an age-appropriate

manner. Counselors can help the mother and children frankly discuss issues surrounding substance use and recovery. A staff member providing therapeutic services for children should conduct substance abuse prevention activities for children of all ages.

While a woman is learning to parent, her children need assistance to overcome the effects of her substance abuse. It is likely their mother has been emotionally and physically unavailable at times. Counselors can help children realize that their mother's behavior was unintentional and, as she regains control of her life, she will likely become more available. In addition,

Alateen; psychoeducational curricula, such as the National Association for Children of

Alcoholics "Celebrating FamiliesTM;" and onsite individual and group therapy can provide further support to children.

*Parenting issues for women with* trauma histories

A history of trauma can affect both how a woman experiences parenting and how effective she is as a parent. Factors that affect a woman's parenting include the extent of trauma history, who the abuser was, and a woman's parenting role models, as well as whether she has been involved with trauma work or has developed the skills to manage trauma memories and feelings (Melnick and Bassuk 2000). Several major parenting issues for trauma survivors can be identified:

* + Many women feel shame, guilt, and self­ blame, which can interfere with their emotional availability to their children. This includes a mother's self-criticism or depression when evaluating current parenting as well as her belief that she

deserves blame for inadequate parenting, or feeling that her children's behavior is an attack because they had inadequate parenting.

* + Interaction with a child can trigger a mother's traumatic past. This includes experiencing a child's misbehavior as a traumatic trigger, children's distress or need for bonding reminding a mother of her own vulnerabilities, and having posttraumatic

stress disorder (PTSD) symptoms triggered by normal developmental events such as breastfeeding, bathing a child, and providing sexual education to a child. Likewise, a mother may experience heightened anxiety and vigilance when one of her children reaches the same age that her own prior sexual abuse or trauma began or occurred.

For example, if a client witnessed her younger brother getting shot when she was 12, she may encounter more traumatic stress symptoms as her oldest child reaches the same age as her brother.

* A mother may internalize and reenact the role of both victim and perpetrator in

response to trauma. This may cause her to worry that her children will be mistreated and lead to either overprotectiveness or helplessness, a reluctance to set limits out of fear of identifying with a perpetrator.

* Female clients will need to come to terms with having been inadequately nurturing parents at times and with the complexities of providing a better relationship with their children (Melnick and Bassuk 2000).

Trauma-informed parent training assists mothers in identifying their triggers, learning appropriate boundaries and discipline, and learning nurturing behaviors so they can care for their children in healthy ways. As the mother becomes more stable, she will need to be prepared for the possibility that her children will feel safer in acting out their previous distress. Programs can prepare women in

early recovery for this predictable event with information, coaching for effective parenting, and reframing the children's behavior as a signal that they feel safer and can afford to express themselves.

*Children who are not in a* mother's care

Regaining custody or re-establishing their role

of primary caregiver can be a major motivating factor for women in treatment. Professionals at all levels of care are encouraged to support the relationship between mothers and children and to support and facilitate ongoing connections with their children in foster care or with

relative caregivers. Since parent-child visiting is an essential ingredient toward reunification, substance abuse treatment providers may be able to provide supervised visits, offering an opportunity for therapeutic intervention and the mother's attention to her relationship with children not in her custody. Yet, numerous factors inhibit visitation, including the mother's health status, transportation needs, and support from others (Kovalesky 2001), and staff should be aware of these variables. Ultimately, counselors will need to help women recognize

how their recovery needs can complicate meeting their children's needs and determine the pacing of reunification efforts.

Occasionally, a mother in substance abuse treatment expresses a desire not to keep her children. The woman may feel unable to be a mother or has no support in doing so, or her children have been cared for by others for a long time. In other cases, it is possible that these children were the result of rape or prostitution. Sometimes it is in the best interest of both the mother and the child(ren) for the mother to relinquish care. Counselors must be careful to allow the decision to belong to the woman, to listen to her ambivalence, and to support her regardless of her decision (CSAT 2001b).

*Children with special needs*

Some mothers with substance use disorders have children with special needs, possibly as a result of alcohol or drug use during pregnancy, inadequate prenatal care, poor nutrition during pregnancy, or other factors. In addition to coping with the personal guilt, mothers will

find that these children demand extra care and attention and create additional stresses during recovery. Careful assessment of these

children by trained professionals is essential. An educational and/or treatment plan should result from an assessment that is integrated with the mother's treatment plan. Because so many of

the children who are included in treatment with their mothers have emotional or developmental problems, there is a real need for child specialists on staff (Conners et al. 2004; CSAT 2000b). A linkage to programs for children

with special needs and children with disabilities would be an asset in providing the services these children need.

History of Trauma

Trauma can result from numerous experiences, including emotional, physical, and sexual abuse, as well as assault, war, natural disasters, terrorism, and interpersonal violence that occurs between family members or with intimate partners. Women who experience or witness violence, particularly actions that threaten

their lives and safety, can become traumatized by these events (Herman 1997). The *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision* (DSM-IV-TR) defines trauma as "involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to

one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced

by a family member or other close associate" (American Psychiatric Association [APAJ 2000a, p. 463).

Women respond to and are affected by trauma in a variety of ways. Based on their histories, circumstances, and other factors, some women experience traumatic stress symptoms that dissipate over time, while other women are resilient to the effects of trauma and recover from it quickly (Foa and Rothbaum 1998).

Some women develop psychological disorders including PTSD and other anxiety and mood disorders, and other women may use alcohol, tobacco, and drugs to cope with the trauma and its symptoms. Still others may replicate their trauma by engaging in problematic parent-child interactions, including abuse and neglect (McMahon and Luthar 1998). A family history of anxiety, early traumatic violence, and repeated exposure to trauma can predispose an individual to develop severe problems. The Adverse Childhood Experiences Study (Felitti et al. 1998) reflected a strong association between health

risk behavior and disease for both adult men

and women to exposure to emotional, physical, or sexual abuse, and household dysfunction during childhood.

*The relationship between trauma* and substance abuse

Substance abuse and victimization appear to be

highly correlated; drug abuse increases the risk of violent assault, and victimization appears to increase the risk of substance abuse (El-Bassel et al. 2005; Kendler et al. 2000; Kilpatrick et al. 1997). Nevertheless, the connection between substance use and abuse and interpersonal violence often is complex, especially for women.

Men who abuse substances are at high risk of committing violence against women and

children. Women who use substances are more at risk for being abused because of relationships with others who abuse substances, impaired judgment while using alcohol or drugs, and being in risky and violence-prone situations (Testa et al. 2003). Survivors of abuse may become dependent on alcohol and drugs to manage trauma symptoms and reduce tension and stress from living in violent situations.

Thus begins a cycle of "victimization, chemical use, retardation of emotional development, limited stress resolution, more chemical

use, and heightened vulnerability to further victimization" (Dayton 2000; Steele 2000, p. 72).

A history of trauma is common in the lives of women with substance use disorders. Female survivors of sexual trauma were found, in one study, to be dependent on more substances, to have had more hospital stays and emergency department visits, and to be less able to care for their children than women who had not been sexually abused (Young and Boyd 2000). Girls who suffer physical and sexual abuse by dating partners are more likely to engage in risky behaviors such as smoking, binge drinking,

and cocaine use (Silverman et al. 2001). In

another study, adverse childhood circumstances predicted binge drinking among **adult** women (Timko 2008).

Alcohol and drug use by trauma survivors can be adaptive at first. Some victims use substances to numb psychological effects of the trauma.

Some substances help survivors dissociate the trauma from their consciousness (Herman 1997). Women who have histories of violence and trauma have a higher propensity for substance use disorders and are more likely to encounter a difficult recovery from substance use disorders. Their treatment is typically complicated because of the interrelationship between trauma and substance use, the role that substances play

in managing traumatic stress symptoms, and sequelae from the experience of trauma such as depression and other psychological disorders. To obtain more specific information on the impact of trauma, traumatic stress disorders, symptoms of PTSD and associated symptoms, and treatment approaches, refer to TIP 42 *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005e) and the planned TIP *Substance Abuse and Trauma* (CSAT in development *h).*

*Interpersonal violence*

Violence dramatically affects the physical and emotional health of victims and witnesses.

The United Nations defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life" (United Nations General Assembly 1993, p. 2). The National Violence Against Women Survey (Tjaden and Thoennes 1998; 2000; 2006), conducted in 1996, estimated that in the year before the survey, almost 2 million women were physically assaulted and more than 300,000 women experienced a completed or attempted rape. Estimates of lifetime incidence increased to more than 50 million women who were physically assaulted and almost 20 million who experienced rape or attempted rape. Moreover, sociologists have commented that this level of violence has created a culture of fear for many women, observing that women feel they need

to be alert and aware of their surroundings to protect themselves against assault and rape (Gordon and Riger 1989).

Women are more likely to become victims of intimate partner abuse (Catalano 2007), and men and women become victims of interpersonal violence under different circumstances. Women often experience violence in the privacy of their home (Catalano 2007; Covington *2002a;* Tjaden and Thoennes 2006). Both boys and girls are at risk for physical and sexual abuse by parents and people they know, but this risk changes over the course of life. As girls move into adolescence and adulthood, they continue to be at risk for interpersonal violence. Often their abuser is someone with whom they have a relationship.

For example, about one in five high school girls reportedly has suffered sexual or physical

abuse from a boyfriend (Ackard and Neumark­ Sztainer 2003; Silverman et al. 2001, 2004).

For an overview of violence and women, see Figure 7-1.

Violence and abuse also occur in lesbian relationships. While research is limited, studies

reviewed by Renzetti (1993) have indicated that lesbians experience partner violence at about the same rate as heterosexual women. As is the case with violence in heterosexual relationships, alcohol consumption often is part of the battering (Schilit et al. 1990). In comparing

the prevalence of domestic violence between homosexual males and females, the National Coalition of Anti-Violence Programs (2007) reports there are no overall differences.

*Childhood sexual and physical* abuse

A history of childhood sexual or physical abuse

(or both) is a significant risk factor for the development of a substance use disorder (Evans and Sullivan 1995). Two models help explain this-the distress coping model and the emotion regulation model. It is likely that substances

not only serve as means of coping with negative emotions generated by childhood abuse, but

*Figure 7-1* Violence and Women

* + The strongest risk factor for being a victim of intimate partner violence is being female.
  + One of every six women has been forcibly raped at some time in her life, and women are as likely to be raped as adults as they are as minors.
  + While women are at a significantly greater risk in comparison to men of being raped by all types of offenders, 43 percent of all female victims were raped by either a current or former intimate partner.
  + Between 25 and 50 percent of women will be abused by male partners during their lifetime.
  + Women are injured as a result of domestic violence about 13 times more frequently than men.
  + Women with fewer resources or greater perceived vulnerability-girls and those experiencing physical or psychiatric disabilities or living below the poverty line-are at even greater risk for domestic violence and lifetime abuse.
  + Interpersonal violence is characterized by a pattern of physical, sexual, or psychological abuse. The most common pattern in domestic violence is escalation in frequency and severity over time.
  + When women are violent toward family members, it often is in self-defense.
  + A history of intrafamilial violence may be the most influential risk factor for a woman's abuse of substances.
  + Violence in the media significantly affects attitudes and behaviors related to violence. It increases fear and mistrust, desensitizes people to violence, and glamorizes risk-taking behaviors and violence.

*Source:* American Psychological Association 1996; Brownridge 2006; Tjaden and Thoennes 2006

in regulating emotions by enhancing positive feelings (Grayson and Nolen-Hoeksema 2005; Simpson 2003; Ullman et al. 2005).

A study of 1,411 women born between 1934 and 1974 found that women who experienced any type of sexual abuse in childhood were more likely than those who were not abused to report drug or alcohol dependence as adults. In fact, childhood sexual abuse was associated more strongly with drug or alcohol dependence than with any other psychiatric disorder. This study is based on data from women in the general population, as opposed to clinical studies of women in treatment (Kendler et al. 2000).

Clinical studies have documented that up to 75 percent of women in substance abuse treatment have a history of physical and/or sexual abuse (Ouimette et al. 2000; Teusch 1997). Earlier studies have shown that women who abuse substances are estimated to have a 30- to

1. percent rate of current PTSD (Najavits et al. 1998), which is higher than the rate in men who abuse substances (CSAT 2005a). A history of sexual and/or physical abuse puts women at risk for psychiatric hospitalization (Carmen 1995), depression (Herman 1997; Ross-Durow and Boyd 2000), eating disorders (Curtis et

al. 2005; Janes 1994; Miller 1994; Smolak and Murnen 2001), and self-inflicted injury (Dallam 1997; Haswell and Graham 1996; Miller and Guidry 2001). See also TIP 36 *Substance Abuse Treatmentfor Persons With Child Abuse and Neglect Issues* (CSAT 2000b).

Co-Occurring Disorders

When working with women with co-occurring mental and substance use disorders, substance abuse treatment counselors need to apply

the tools of the mental health professional, especially in knowing when and where to refer clients with co-occurring disorders.

Substance abuse treatment providers do not necessarily have to he trained as mental health professionals, but making appropriate referrals and coordinating the services needed by these clients requires a solid grasp of the differences in treatments, role of medications, and available resources. The following section provides an overview of co-occurring issues and highlights

three disorders that are prevalent in substance abuse treatment among women. For more in­ depth coverage of treatment for those with co­ occurring substance use and mental disorders, review TIP 42 *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005e).

*An overview of issues*

Both the substance abuse and mental health care fields understand that clients can

enter treatment with issues they perceive as interwoven, whether or not the services

themselves are. To address the dilemmas facing the people they serve, mental health, substance abuse, and trauma services are opening a dialog with one another, paving the way toward providing an appropriate, integrated system of care for each client in every system.

An integrated care framework provides assessment and treatment wherever the woman enters the treatment system, ensures necessary consultation for her issues when

a given individual or program does not have the necessary expertise, and encourages all

counselors and programs to develop competence in addressing co-occurring disorders. When women are assessed at a facility that does not have all the services they need, staff members

at that facility are responsible for ensuring that the women are assessed at other appropriate facilities. Too often, services may over- or under-treat one of the disorders (Miller 1994a). Staff members also are responsible for following up with the cooperating facility to ensure that clients receive proper care.

The need for ongoing evaluation of co-occurring disorders is critical because both substance abuse and substance withdrawal can mimic

or mask co-occurring psychiatric disorders. The client's internal turmoil can result in overwhelming affect and chaotic behavior that creates heavy demands for providers. Women with co-occurring substance use and mental

disorders are likely to have PTSD, other anxiety disorders, depression, or eating disorders (particularly bulimia). While women are also more willing to identify social and psychiatric problems, they appear to have more difficulty

in acknowledging problems with substance use (Mangrum et al. 2006). Treatment services that provide an integrated system of care

can naturally assist women in exploring the interaction and impact of substances and mental health without supporting or reinforcing the polarization of each disorder that can arise when one disorder is easier to acknowledge by the client.

Co-occurring mental and substance use disorders often result in poor psychosocial functioning, health problems, medication noncompliance, relapse, hospitalizations, homelessness, and suicidal behavior (Reed and Mowbray 1999). Co-occurring disorders

are associated with poorer treatment outcomes for women with substance use disorders and contribute to high rates of treatment dropout (Bernstein 2000). Among women in the child welfare system, the prevalence of co-occurring disorders is high and the need for services is paramount. More often than not, mothers' co­ occurring disorders interfere with the likelihood of family reunification-especially if there are numerous needs, such as vocational, housing, and mental health services (Choi and Ryan 2007). Thus, appropriate referrals and case management are needed to retain these clients in substance abuse treatment and to afford the best possible outcome for women and their children.

*Pregnant women and co-occurring* mental illness

Pregnancy can aggravate the symptoms of co­

occurring mental illness. This can be a result of the hormonal changes and stresses that occur during pregnancy, some medications given during pregnancy or delivery, the stresses of labor and delivery, the challenges and hormonal changes with lactation, and adjusting to and bonding with a newborn (Grella 1997). Women with co-occurring disorders sometimes avoid early prenatal care, have difficulty complying with healthcare providers' instructions, and are unable to plan for their babies or care for them when they arrive. According to the literature, women with anxiety disorders or personality disorders have a greater risk of postpartum depression (Grella 1997), and mood disorders affect treatment outcome among pregnant women who are drug dependent (Fitzsimons

et al. 2007). More outcome research is needed to evaluate the role of co-occurring disorders among pregnant women and the impact of

treatment for co-occurring disorders on prenatal and postnatal care.

It is important to remember that women can become depressed not only after childbirth but during pregnancy. According to the National Women's Health Information Center (HHS

***Advice to Clinicians:***

**Women With Co-Occurring Disorders**

* Provide women who have co-occurring disorders with comprehensive coordinated services using an integrated treatment model.
* Screen and assess for trauma as a standard practice for women in treatment for substance use disorders.
* View services as long term, suggesting a range of continuing care services and peer support, such as 12-Step programs, group therapy, or women's support groups.
* Maintain regular contact with clients and advocate for them; adapt case management models that promote regular contact with clients.
* Attend to a client's reaction to medication and compliance, particularly when a woman is treated for psychiatric illnesses. Learn about medications effective for anxiety, depression, and other mental disorders; their safety profile, side effects, and possibilities for cross-addiction; and length of time needed for symptoms to decrease.
* Offer encouragement to women with co-occurring disorders and reward them for gains made in treatment to help them establish a stronger sense of self-worth.

*Source:* DiNitto and Crisp 2002.

*Postpartum Depression: An Under-Diagnosed Disorder*

According to the DSM-IV-TR (APA *2000a),* postpartum depression begins within 4 weeks after delivery. Episodes occurring after this period are considered "ordinary" depression. Risk factors for postpartum depression include a history of depression, psychological distress or psychiatric diagnosis before or during pregnancy, or a family history of psychiatric disorders (Nielsen Forman et al. 2000; Steiner 2002; Webster et al. 2000). Prospects for recovery from postpartum depression are good with supportive psychological counseling accompanied as needed by pharmacological therapy (Chabrol et al. 2002; Cohen et al. 2001; O'Hara et al.

2000). Antidepressants, anxiolytic medications, and even electroconvulsive therapy have all been successful in treating postpartum depression (Griffiths et al. 1989; Oates 1989; Varan et al. 1985). (Note that some medications pass into breast milk and can cause infant sedation.) Patients with postpartum depression need to be monitored for thoughts of suicide, infanticide, and progression of psychosis in addition to their response to treatment.

The term "postpartum depression" encompasses at least three different entities:

* + Postpartum or maternity "blues," which affects up to 85 percent of new mothers
  + Postpartum depression, which affects between 10 and 15 percent of new mothers
  + Postpartum psychosis, which develops following about one per 500-1,000 births, according to some studies (Steiner 1998)

*Postpartum blues* is temporary depression occurring most commonly within 3-10 days after delivery and may be caused by progesterone withdrawal (Harris et al. 1994), a woman's emotional letdown that follows the excitement and fears of pregnancy and delivery, the discomforts of the period immediately after giving birth, fatigue from loss of sleep during labor and while hospitalized, energy expenditure at labor, anxieties about her ability to care for her child at home, and fears that she maybe unattractive to her partner. Anticipation and preventive reassurance throughout pregnancy can prevent postpartum blues from becoming a problem. Women with sleep deprivation should be assisted in getting proper rest. Symptoms include weepiness, insomnia, depression, anxiety, poor concentration, moodiness, and

irritability. These symptoms tend to be mild and fleeting, and women usually recover completely with rest and reassurance. Followup care should ensure that the woman is making sufficient progress and not heading toward a relapse to substance abuse.

*Postpartum depression* is a more severe case of the postpartum blues that does not go away after a few days. Beyond the temporary weepiness, irritability, and emotional letdown

that follows delivery, postpartum depression involves a longer-term experience of despair, discouragement, guilt, self-reproach, and withdrawal from social contact. In many ways, postpartum depression resembles the grief and mourning that follows bereavement. Women may also lose their appetite and thus also lose weight, experience insomnia and severe mood swings, and have trouble coping with simple daily tasks, including the care of their newborns.

*Postpartum psychosis* is a severe mental disorder. Women with this disorder lose touch with reality and may have delusions, hallucinations, and/or disorganized speech or behavior. Women most likely to be diagnosed with postpartum psychosis are those with previous diagnoses

of bipolar disorder, schizophrenia, or schizoaffective disorder, or women who had a major depression in the year preceding birth (Kumar et al. 2003). Other studies reviewed by Marks and colleagues (1991) indicate that other risk factors for postpartum psychosis include previous depressive illness or postpartum psychosis, first pregnancy, and family history of mental illness. Recurrence of postpartum psychosis in the next pregnancy occurs in 30-50 percent of women (APA *2000a).* Peak onset is 10-14 days after delivery but can occur any time within 6 months. In most cases, the severity of the symptoms mandates pharmacological treatment and sometimes hospitalization. The risk of self-harm and/or infanticide is widely reported and monitoring of mother-infant by trained personnel can limit these occurrences.

2009), several factors increase a woman's chance of depression prior to delivery: minimal support from family and friends, a history of depression or substance abuse, a family history of mental illness; anxiety about the condition of the fetus, problems with previous pregnancies or birth(s), relational or financial problems, and age of mother (younger women).

Many pregnant women with co-occurring disorders are distrustful of substance abuse and mental health treatment providers, yet they are in need of multiple services (Grella 1997). One concern is whether the mother can care adequately for her newborn. For her to do so requires family-centered, coordinated efforts from such caregivers as social workers, child welfare professionals, and the foster care system. It is particularly important to make careful treatment plans for women with mental health problems that include planning for childbirth and infant care. Women are often concerned about the effect of their medications on their fetuses. The consensus panel believes that treatment programs should work to maintain a client's medical and psychological stability during her pregnancy and collaborate with other healthcare providers to ensure that

treatment is coordinated. Providers also need to allow for evaluation over time for women with co-occurring disorders. Re-assessments should occur as they progress through treatment.

###### Anxiety Disorders

Anxiety disorders encompass physiological sensations of nervousness and tension, psychological worry characterized often by apprehension and rumination, and behavioral patterns of avoidance linked to the perceived

source of anxiety. Some anxiety disorders have stronger familial ties than others. Anxiety disorders can develop without an identified stressor or event or by exposure to acute or prolonged stress, (such as a traumatic event or a chronic condition such as living with poverty, in a dysfunctional family system, or as a result of migration and acculturation). PTSD, panic disorders, agoraphobia without panic, simple phobia, and generalized anxiety disorder are more common among women than among men (APA *2000a;* Kessler et al. 1994; NIMH 2007).

Among individuals with substance use disorders, traumatic stress reactions and PTSD are quite prevalent among women. As a result, this section will primarily focus on PTSD starting with

a brief overview of treatment considerations for women with anxiety disorders. For more

detailed information regarding anxiety disorders and trauma, refer to TIP 42 *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005e) and the planned

**TIP** *Substance Abuse and Trauma* (CSAT **in**

development *h).*

*General treatment considerations* for anxiety disorders

Women with anxiety disorders often seek

medical help for physical (somatic) complaints such as fatigue, trembling, palpitations, sweating, irritability, sleeping problems, eating problems, irritable bowel syndrome, chronic pain, or dizziness. The symptoms of substance use and anxiety disorders are easily confused; therefore, abstinence must be established before a woman in substance abuse treatment is diagnosed with anxiety disorder. However, this does not preclude providers from working with

It is important to remember that women can become depressed not only after childbirth but during pregnancy. According to the National Women's Health Information Center (HHS 2009), several factors increase a woman's chance of depression prior to delivery: minimal support from family and friends, a history of depression or substance abuse, a family history of mental illness; anxiety about the condition of the fetus, problems with previous pregnancies or birth(s), relational or financial problems, and age of mother (younger women).

***Note* to *Clinicians***

women to develop coping skills and strategies to manage the symptoms of anxiety.

Cognitive-behavioral therapies (CBT) are effective treatments for anxiety disorders (Hofmann and Smits 2008) including, but not limited to, stress inoculation and other

anxiety management strategies, desensitization processes, and imaginal and in-vivo (live reenactments) exposure therapies. Nonetheless, other types of therapy that address the underlying stress-producing events may be required (Frank et al. 1998). Clinical experience indicates that women with anxiety disorders

and substance use problems may benefit from alternative therapies as an adjunct to CBT, including acupuncture, exercise, and mindfulness meditation. One study indicated that socially phobic female outpatients

being treated for alcohol dependence had better outcomes with CBT than with 12-Step facilitation therapy (Thevos et al. 2000).

Benzodiazepines, which are commonly prescribed for anxiety disorders, can also be addictive and thus present a major problem for women with a substance use disorder. Providers may prescribe sedating antidepressants or selective serotonin reuptake inhibitors (SSRis; Zweben 1996) instead. Newer nonaddicting medications, both SSRis and non-SSRis, are being prescribed as anti-anxiety agents **(NIMH** 2007). Other options include anticonvulsants, antihypertensive agents, and newer neuroleptic medications.

*PTSD*

Although some type of trauma has been experienced by many women who use substances, not all women who have been traumatized will develop PTSD. An anxiety disorder, PTSD may involve other anxiety symptoms including panic attacks and avoidance (Brady et al. 2000). Refer to Appendix E for

DSM-IV-TR criteria for PTSD. For those women who have PTSD, their symptoms will involve persistent re-experiencing of trauma­ related events, avoidance of trauma-related material, and arousal (APA 2000a; Refer to Figure 7-2, p. 162, for PTSD symptom clusters). In addition, they will present other associated symptoms, such as depression and sleep disturbance. Subsequent to a heightened state of arousal, many women report significant sleep difficulties characterized by nightmares, trouble falling sleep, frequent awakenings or problems in staying asleep, and apprehension in going to sleep. Among women with a history of sexual assault and PTSD, sleep difficulties have been noted as a significant motive to drink (Nishith et al. 2001).

Along with the physiological and psychological symptoms that so often characterize PTSD, the experience of trauma can impact core assumptions and beliefs about self, others, and life (for review, see Janoff-Bulman 1992). One study (Hall 2000) demonstrated that the severity of the effects of trauma is evident

in two core beliefs identified by survivors of childhood abuse who are in recovery: "I am nothing" (feeling inconsequential) and "I am bad or wrong." In addition to the abuse or trauma itself, experiences that lead to feeling inconsequential include being unprotected from danger, telling someone about the abuse but

not being believed, being told lies to conceal the abuse, and being unprepared for life transitions. This can lead to shutting down emotions and social isolation (Boyd and Mackey *2000a;* Hall 2000). The perpetrator may have put the blame on them ("you asked for it").

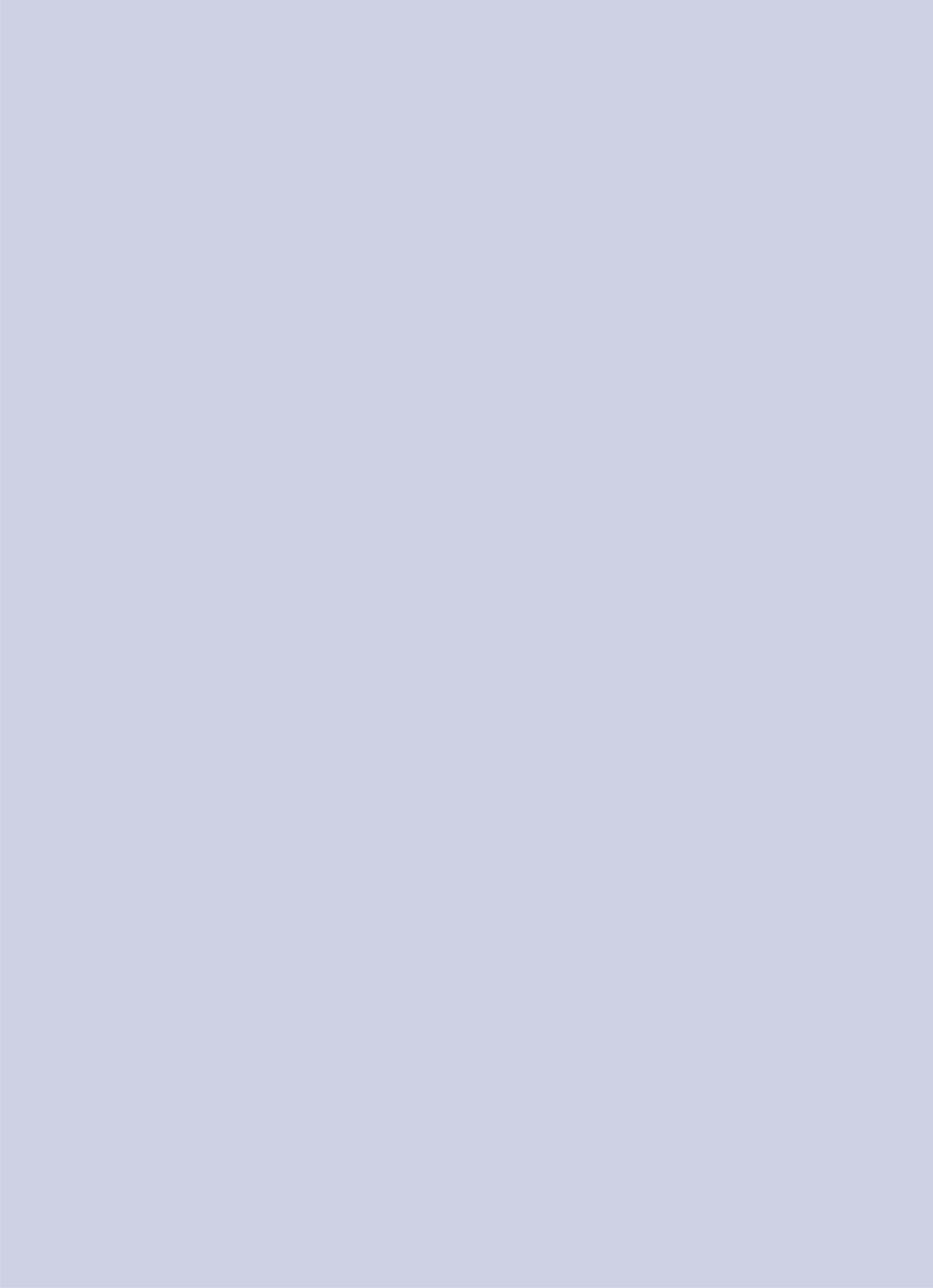
*Treatment of PTSD*

Unlike other memories, memories of traumatic events may seem to have vague cognitive content. Rather, they often are sensory fragments such as

Anxiety in a client can increase a counselor's anxiety. A tip for staff working with women who abuse substances with anxiety disorders is to "slow down," that is, start with general and non­ provocative topics and proceed gradually as clients become more comfortable talking about issues.

***Note to Clinicians***

|  |  |  |
| --- | --- | --- |
| ***Figure 7-2 PTSD Symptoms*** | | |
| **Symptoms** | **Client Experience** | **Clinical Suggestions** |
| **Reexperiencing**   * Flashbacks * Intrusive memories * Nightmares | * Feelings of being tossed from present and thrown into the nightmare of the past * Feeling of being out-of-control * Feeling of incompetence in managing symptoms or triggers | * Grounding techniques * Develop support system * Education about trauma and the symptoms of PTSD * Create sense of safety * Sleep hygiene strategies * lmaginal rehearsal of dreams * Cognitive and coping skills to help separate past experiences from present n1on1ent |
| **Hyperarousal**   * Heightened startle response * Irritability or heightened aggression * Hypervigilance of environment * Sleep disturbance | * All-or-none thinking * Fatigue * Feeling overwhelmed and terror of being overwhelmed by feelings * Difficulty in managing anxiety and engaging in self-soothing skills | * Normalize the symptoms * Ability to reassure * Containment strategies * Increasing coping and self-soothing capacities * Anxiety management training * Cognitive restructuring |
| **Numbing and Avoidance**   * Staying away from persons, places, and things that remind client of trauma | * Disconnection from others' and own feelings * Mechanical experience of life; possible discussion of painful events with limited affect * Dissociation (not knowing or remembering events or periods or experiencing   oneself as separate from what one was experiencing)   * Repeated use of substances or engagement in behaviors to avoid distress * Isolation; profound loneliness * Ineffective defense against overwhelming feelings | * Affect regulation skills * Cognitive-behavioral strategies to build coping skills * Education regarding substance use disorders and opportunities   to draw connections between substance use and distress   * When appropriate and with adequate training, use exposure strategies including desensitization, eye movement desensitization and reprocessing, prolonged exposure therapies |
| *Sources:* APA *2000a;* Cramer 2000; Melnick and Bassuk 2000; and Najavits *2002b.* | | |



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sights, sounds, smells, or kinesthetic sensations and emotional states (van der Kolk 1996).

Developing the ability to organize the traumatic events into coherent thoughts and narrative that can be expressed in some way can significantly lessen somatic symptoms (see Figure 7-3; van der Kolk 1996). Some treatment methods support the premise that the trauma must be made conscious, effectively experienced, and integrated into present life (Volkman 1993).

Some treatments suggest that coping strategies are the effective path in addressing PTSD, while other approaches heavily rely on the premise that repeated and prolonged exposure to anxiety-evoking material will gradually reduce PTSD symptoms through the process of extinction/habituation (Foa et al. 2007). A

review of psychological treatments for PTSD is beyond the scope of this TIP. For a review of treatments, refer to the article, *Psychosocial treatment of posttraumatic stress disorder: A practice-friendly review of outcome research* (Solomon and Johnson 2002), along with the TIPs highlighted in the introduction to the Anxiety Disorders section earlier in this chapter.

*Women with substance use* disorders and PTSD

Substance abuse and the effects of trauma

interact in complex ways in an individual. A treatment provider cannot assume that one is

a primary problem and the other secondary. Nor is it always beneficial to delay working on trauma symptoms until the client has been

abstinent for a predetermined minimum amount of time. The counselor should focus on the client's current crisis and stabilizing her affect.

Substance abuse can prevent full recovery from PTSD, and continuing PTSD symptoms may perpetuate use of substances and the development of substance use disorders. Two studies report double the lifetime prevalence of PTSD in women than in men: 11.3 percent versus 6 percent and 10.4 percent versus 5

percent (Breslau et al. 1991; Kessler et al. 1995, respectively). These studies found that women were twice as likely as men to develop PTSD after exposure to a trauma, suggesting that women are particularly vulnerable to PTSD or that the particular type of trauma experienced by women is more likely to result in PTSD. In

a study that sampled 558 cocaine-dependent outpatient clients on current rates and symptoms of PTSD, women were three times more likely to meet diagnostic criteria for PTSD (Najavits et al. 2003).

Najavits and colleagues (1997) cite studies demonstrating that women with substance use disorders have higher rates of PTSD (30 to 60 percent) in comparison to men, most often as the result of physical or sexual assault. Women **with** substance use disorders have also been found to

***Figure 7-3 Helpful Skills for Trauma Victims***

* Self-knowledge, including attention to bodily cues
* Self-regulation, including recognizing triggers and expressing emotions appropriately
* Self-soothing; for example, using relaxation or guided imagery and keeping a journal
* Self-esteem and recognizing which behaviors to change
* Self-trust, including learning when to trust one's own judgment and how to make decisions
* Limit setting and assertiveness, including recognizing personal limits and defending them
* Clear expression of needs and desires; for example, identifying a need, evaluating the need, and planning how to fill it
* Realization that the healthiest relationships have mutuality and reciprocity and learning to create them

Source: Adapted from Harris and Fallot 2001a.

have higher rates of repeated trauma by family perpetrators than men who abuse substances (Grice et al. 1995). Rape has been found to be the most likely form of violence to lead to PTSD for both women and men, and female rape victims may be particularly vulnerable to developing substance use disorders because of the traumatic nature of rape (Kessler et al. 1997).

More research is needed in evaluating outcome and the role of PTSD and relapse. Women who relapse often are labeled as "resistant" when, in fact, victimizations that have not been addressed could account for the difficulty in stopping substance abuse (Root 1989). Trauma survivors sometimes use alcohol and drugs to medicate the pain of trauma and consequently are perceived as "treatment failures" because their trauma experience is misunderstood or not identified (Covington 2008a rev., 1999a). In an outcome study comparing women with and without PTSD in treatment for substance use disorders, the authors found that individuals with both PTSD and substance use disorders relapsed more quickly and that PTSD was a predictor of relapse (Brown et al. 1996).

While women with PTSD appear to possess more psychological risk factors associated with relapse than men, another outcome study comparing men and women in an outpatient treatment setting highlighted that women are more likely to engage in treatment, thereby offsetting the higher risks for relapse (Gil-Rivas et al. 1996). Women with PTSD may benefit from relapse prevention therapy as an effective short-term treatment for substance use disorders and PTSD. In a study evaluating the efficacy of cognitive-behavioral relapse prevention therapy for substance use disorders (only), the "Seeking Safety" program (manual-based treatment for substance abuse and PTSD), versus "standard" community

care, women who were engaged in either relapse prevention therapy or the "Seeking Safety" program showed sustained improvement in substance use and PTSD symptoms at 6- and

9-month followups in comparison to women in standard care (Hien et al. 2004).

*Substance abuse treatment:* Trauma-informed treatment approach

When providing treatment, clinicians need to

be aware that most female clients are trauma survivors, even if they do not meet criteria for PTSD. During the past 20 years, the treatment community responded to this treatment need in varying ways. Several years ago, most providers first treated the substance use disorder then addressed trauma-related issues later. As knowledge in the field grew, collateral services were offered that treated substance abuse

and trauma issues concurrently. A "trauma­ informed" program has an awareness of the pervasiveness of traumatic events and translates that awareness into integrated services

that support the coping capacity of clients. This capacity enables a woman to stay and participate in treatment, to engage in a positive therapeutic alliance, and to learn to cope with the aftermath or consequences of trauma. The

text box below provides an example of a trauma­ informed approach to treatment.

A trauma-informed approach adjusts services to meet the needs of women who have a history of trauma. In 6- and 12-month outcome studies evaluating program and person-level effects among women with co-occurring disorders and trauma (Morrissey et al. 2005; Morrissey et

al. 2005a), programs that provided integrated services (mental health, substance abuse, and trauma) displayed increased positive effects on mental health and substance use outcomes.

Programs can use Appendix F, Integration Self­ Assessment for Providers, to determine the extent to which their agency integrates treatment for substance abuse, mental illness, and trauma.

To be trauma-informed means to know of past and current abuse in the life of a woman. But more importantly, it means to understand

the roles that violence and victimization play in the lives of women seeking substance abuse and mental health services, to design

integrated service systems that accommodate the vulnerabilities of a trauma survivor, and to deliver services that facilitate participation

in treatment (Harris and Fallott 2001b). Being trauma-informed does not mean that the program forces clients to reveal their trauma unwillingly. Nor does it mean that substance abuse treatment counselors need the level of expertise that is required to help women resolve all their problems related to trauma. However, knowledge about violence against women and the effects of trauma helps counselors to:

* Consider trauma when making assessments and treatment plans.
* Avoid triggering trauma reactions or retraumatizing women.
* Adjust staff behavior with clients and other staff members, and modify the organizational climate to support clients' coping capacities and safety concerns.
* Allow survivors to manage their trauma symptoms successfully so that they can access and continue to benefit from treatment services.
* Emphasize skills and strengths, interactive education, growth, and change beyond stabilization.

*Clinical considerations in trauma­* informed services

A history of trauma should alert counselors to

the potential for co-occurring mental disorders, such as PTSD, depression, anxiety disorder,

or personality disorders that can impede treatment unless addressed early. Once the trauma has been identified either during the assessment process or in early treatment, the

*The Women Embracing Life and Living (WELL) Project*

The aim of the SAMHSA-funded Women Enhancing Life and Living (WELL) Project was both to integrate treatment services and to encourage trauma-informed services for women with co­ occurring substance use and mental disorders who have histories of violence. The project used relational strategies to facilitate systems change across three systems levels: local treatment providers, community or regional agencies, and the State government.

Substance abuse treatment clinicians in the study reported they tended to be insensitive to trauma/violence issues because they were unaware of the overlap between these two issues (there were notable exceptions among staff at programs that were gender-specific and evidence-based). Clinicians who were cross-trained or attempted to provide a broader range of services to clients often encountered restrictions embedded in existing procedures, forms, and documentation requirements that made integrated care more difficult.

Clients in the study recounted their frustration at having to slant their histories depending on the agency or practitioner they were addressing, and at having to conceal part of their histories to receive certain services. Rather than promoting wholeness and recovery, the experience in the treatment program recreated the secrecy of abuse and fed the stigma associated with their illnesses.

The WELL project worked within three communities to address this fragmentation and to increase awareness of the importance of integrating an understanding of trauma into services offered to women. It began by convening leadership councils at the State and the local levels. Project activities included cross-training for clinicians, convening a consumer advisory group to provide guidance, submission of recommendations from the local leadership councils to the State level, and visits by consultants to each agency to assist clinicians in putting their training into practice. These activities resulted in greater understanding of trauma-related issues by clinicians, stronger linkages to community services for women with histories of trauma, and more referrals to these services.

*Source:* Markoff et al. 2005.

Preliminary data support that integrated trauma-focused interventions for women in substance abuse treatment programs appear to be safe, thus presenting no differences in adverse psychiatric and substance abuse symptoms or events in comparison to standard care (Killeen et al. 2008). So often, clinicians and administrators fear and hold the misperception that addressing trauma-related issues is counterproductive and produces deleterious effects on women in substance abuse treatment. While the selection of services and the planning

on how these services are delivered is important in maintaining the integrity of care for the client, integrated trauma-focused interventions are not only a viable option but an essential component of treatment for women with substance use disorders.

***Note* to *Clinicians and Administrators***

counselor can begin to validate a woman's experience and acknowledge that she is neither unique in her experience nor alone. If women are not questioned directly, the abuse may go unrecognized and untreated. Many women who are dependent on alcohol or drugs experience difficulty in recovery and relapse if violence and abuse issues are not addressed in treatment.

Women may need help understanding the serious long-term effects of violence, sexual abuse, and incest on their functioning and on the risk of relapse (Covington 2003; Finkelstein 1996; Najavits 2006).

In many instances, counselors can address trauma and its relevance to substance abuse treatment effectively. In other cases, complex or severe problems related to trauma that exceed the counselor's competence may be present initially or may arise during treatment. Clients with such problems should be referred to a specialist-typically a licensed mental health professional trained in trauma within the treatment program. Trauma-informed counselors can recognize when a therapeutic relationship is stretching their abilities, but the

decision to refer a client requires understanding of the situation and supervisory consultation and agreement.

Major trauma-related clinical issues that counselors need to address or attend to during the course of treatment include:

* + *Outreach.* Efforts to engage women in treatment include flexible scheduling, ready availability, identification of client interest in and need for treatment, and ongoing

evaluation. Outreach includes informing the community of services offered and initiating contact with agencies that should refer women for assessment and counseling (Elliott et al. 2005).

* *Assessment and referral.* A counselor needs to understand the nature of a woman's exposure to trauma-the type of abuse, when it occurred, whether it was a one-time event or repeated over time, the relationship between the client and the perpetrator (family member, acquaintance, stranger), and what occurred if the woman previously disclosed the experience (Bernstein 2000).

It requires treatment by a clinician who is trained in treating traumatic stress disorders. Women who score high on a

posttraumatic stress assessment should be referred for treatment to address their PTSD concurrently with their substance abuse treatment. Counselors should be candid when they cannot provide the treatment the client needs and may need to make a referral.

* *Psychoeducation.* One of the counselor's major functions in treating a woman in recovery who has a trauma history is

to acknowledge the connection between substance abuse and trauma. This acknowledgment validates a woman's experience and helps her feel that she is not alone and that her experience is not shameful. Sharing prevalence data can reduce her sense of isolation and shame (Finkelstein 1996).

* *Normalizing the symptoms.* In addition, it is important to educate and discuss the

***Advice to Clinicians:***

When Is a Woman Ready for Trauma Processing?

Many counselors and clients assume that "working on trauma" means telling the story of what happened. Although exposure therapy is a widely known treatment method (Foa and Rothbaum 1998), it is controversial in the substance abuse treatment field.

Questions remain about whether it is a safe treatment to conduct with clients who are abusing substances or engaged in self-destructive behavior. A study on exposure therapy for people in substance abuse treatment showed that many clients could not tolerate the work, with 61.5 percent not completing the minimum dose of treatment. Those who engaged in the treatment did well in outcomes-including reducing substance use and employment problems-but more research is needed to determine client factors that would identify who would best benefit from this type of treatment (Brady et al. 2001).

Some experts recommend not asking the client to tell her story until she has achieved some abstinence or safe functioning, whereas others assert that this is a case-by-case decision. Staff and clients should not be led to believe that the "real work" is telling the trauma story. CBT is equally effective and may be preferred for some. Najavits (1998) has identified signs to determine when a woman with substance abuse disorder is ready for trauma-exploration work:

* She is able to use some coping skills.
* She has no major current crises or instability (e.g., homelessness, domestic violence).
* She wants to do this type of work.
* She can reach out for help when in danger.
* She is not using substances to such a degree that emotionally upsetting work may increase her use.
* Her suicidality has been evaluated and taken into account.
* She is in a system of care that is stable and consistent, with no immediate planned changes (e.g., discharge from inpatient unit or residential program).

typical symptoms associated with PTSD to help normalize the client's physiological and psychological experience. Similar to other anxiety disorders, clients are often overwhelmed by symptoms leading to the

belief that they cannot manage them or that they are not going to survive them. Some relief arrives when a client knows that they are having a normal reaction to an abnormal event or set of circumstances.

* + *Safety, support, and collaboration.* Trauma often creates profound disconnection in

two areas: interpersonal relationships and internal feelings. Some women who

experience traumas become isolated, feeling that the only safety is in solitude; others compulsively reenact dangerous relationships (Najavits 2002b). Alternating between the

experience of feeling overwhelmed and shutting down, women come to treatment profoundly discouraged about the value and safety of relationships. For a client, safety is psychological and physical, internal and external. A major goal of treatment is to develop a therapeutic alliance. Ideally this alliance creates a safe place within which the woman can learn to trust and have new, meaningful experiences. For a substance abuse treatment program, safety is an organizational or system issue that calls for counselor readiness, collaboration with the client, staff training and supervision, and continual self-assessment of strengths and limitations (Markoff et al. 2005).

* *Tracking level of distress.* Counselors need to monitor their own and their clients' level

of distress. Counselors must observe the client for signs of discomfort. For example, if a client is hyperventilating, the counselor needs to help the client gain mastery of her breathing before proceeding. Using a scale of 1 to 100 to measure the client's subjective units of distress (SUD scale) can be a helpful tool in assessing the client's perception

of current distress and in comparing her levels of distress from one session to the next (Wolpe 1969). It also provides tangible feedback to both the counselor and client.

* + *Regulation of level of closeness and distance.* Carefully maintained boundaries between the counselor and the client maximize the effectiveness of the therapeutic relationship and ensure that treatment does not re-create the original trauma. For example, counselors should not physically intrude on a client who

is "shut down"-does not want to be touched.

* + *Timing and pacing.* The counselor addresses trauma issues when the woman is ready

and functioning at a level where it is safe for her to explore the trauma; timing is directed by the client. The counselor helps the client identify when she is beginning to feel overwhelmed and how she can slow the process down. Trauma treatment begins with the start of substance abuse treatment and needs to be conducted in a careful and clinically sensitive manner. It is not always clear when and under what conditions it is helpful to a client to tell her trauma story. Sometimes results of this work are positive,

but the telling can be harmful when the client does not yet have coping resources to handle the intense telling. Recalling or talking about her traumatic experience can retraumatize a woman. Even if the client wishes to talk about her trauma, it may be unwise if she is in an unstable situation (Najavits *2002a)* and does not have a support system or is in danger of decompensa tion.

* + *Coping skills.* A client's knowledge of coping skills helps her manage symptoms and increases her self-sufficiency and self­ efficacy. Counselors and programs need to

incorporate skill development components­ including problemsolving, assertiveness, anger management, communications, and anxiety management-along with stress

inoculation and relaxation techniques. Clients need to focus on both disorders and their interactions. More insight-oriented therapeutic work occurs once clients have attained abstinence and control over PTSD symptoms (Najavits et al. 1996, *2002a).*

Therapy should help women learn to use more healthful methods of coping with negative feelings, interpersonal conflict, and physical discomfort (Stewart et al. 2000).

* *Affect regulation.* Counselors need to assist clients in learning how to increase their tolerance for affective distress. The feeling of jeopardy feels real for both the client and counselor. It is the challenge for the counselor to remain connected with the client during this crisis, neither becoming overwhelmed by the traumatic reenactment nor emotionally abandoning the client by withdrawing (Cramer 2002). Training to handle strong feelings is essential, as is clinical supervision. Like the client, the counselor may feel shame, incompetence,

anxiety, and anger. Emotional support from colleagues and supervisors helps counselors avoid defensiveness, client blaming, detachment, secondary traumatic stress reactions, and **burnout.**

* *Listening skills.* A critical part of therapy for addressing trauma in substance abuse treatment is to help the client gain support and establish safety. Counselors need

to be nonjudgmental, empathetic, and encouraging; creating an environment that validates the client's experience through listening and gentle guidance.

* *Acknowledgment of grief and mourning.* The

client needs time to grieve many losses. While this grieving process begins from the outset of treatment, the intensity of grief reactions often rises as anxiety symptoms dissipate.

* *Case management.* Case managers or

counselors can assist women with solving problems and crisis intervention, locating peer-support groups and afterhours support, and coordinating linkages with other agencies.

* *Triggering and retraumatization.* During treatment, triggering is unavoidable. A trigger sets off a memory of the trauma. It can be a noise, a television show, another

person's presence, or anything that is a reminder of the event. Therapist and client must be prepared for the difficult work of coping with triggers. The client is prepared by learning to identify the triggers and in either developing or enhancing coping and self-soothing skills. The difference between retraumatization and triggering is the therapist's ability to stay connected to the affective experience of the client and the client's knowledge that she will not be totally overwhelmed by her intense feelings (Najavits *2002a;* Russell 1998). Triggering is inevitable; retraumatization is not. Reenactments are inevitable, but if they occur under controlled conditions and the client feels supported and safe with her counselor, retraumatization does not have to occur. All programs need

to be alert to the risk of triggering and retraumatization.

*Models of recovery*

Since the late 19th century, a number of experts have conceptualized recovery from trauma

in stages, describing it in different terms but referring to the same process (Herman 1997). Most of the conceptualizations followed three stages. The first stage is stabilization, preventing further deterioration and ensuring symptom management. During the second stage trauma is remembered, reenacted, and worked through.

Stage three is a return to normal, the time when the client can live with the memories of the trauma, and problems are controlled. In *Trauma and Recovery,* Herman (1997)

describes trauma as a disease of disconnection and provides a three-stage model for recovery: safety, remembrance and mourning, and reconnection. During these stages, clients receive consistent support for recovery from their substance use disorders.

*Stage 1: Safety*

Female trauma survivors in early treatment for substance abuse typically need to be in an all-women group led by a female facilitator.

"Survivors feel unsafe in their bodies They

also feel unsafe in relation to other people" (Herman 1997, p. 160). Counselors can ensure that the environment is free of physical and sexual harassment and assess a woman's risk of domestic violence. Counselors teach women to feel safe internally by using self-soothing techniques to alleviate depression and anxiety rather than turning to drugs (Najavits et al.

1996). Women are helped to feel physically and emotionally safe in their relationships with their counselors. The counselor works to develop the client's trust and to help her make the connection between substance abuse and victimization (Hiebert-Murphy and Woytkiw

***Advice* to *Clinicians:***

**Retraumatization**

Some staff and agency issues that can result in retraumatization of the client include the following:

* Violating the client's boundaries
* Breaking trust with the client
* Unclear expectations
* Inconsistent enforcement of rules
* Chaotic treatment environment
* Rigid agency policies that do not allow a woman to have what she needs to feel safe
* Disruption in routines
* Disrespectfully challenging the client's reports of abuse
* Labeling intense rage and other feelings about the trauma as pathological
* Minimizing, discrediting, or ignoring the client's feelings or responses
* Disrupting relationships because of shift changes and reassignments
* Obtaining urine specimens in a nonprivate manner

*SAMHSA's Women, Co-Occurring Disorders and Violence Study*

***(WCDVS)***

In 1998, SAMHSA funded sites in the United States to develop integrated services for women who were the victims of violence and diagnosed with co-occurring mental and substance abuse disorders; services were also available for these women's children. This 5-year study sought to compare more integrated treatment with non-integrated treatment for more than 2,000 women and yielded information on the effectiveness of the integrated services approach for women.

WCDVS also addressed the interplay of substance use disorders, trauma, and mental illness and demonstrated the empowerment and healing that comes when female clients are involved directly in their care and recovery. Outcomes for women in the study improved more than the outcomes for those in the treatment-as-usual group when women had a voice in the planning, implementation, and delivery of their treatment and received counseling for all three conditions together.

The study showed that to improve treatment, an increased recognition is needed of the effects that past and present traumas have on women in treatment. Women should be encouraged and helped to play an active role in their healing processes. Additional key findings include, but are not limited to, the following: the need for comprehensive assessment that incorporates the history of trauma, physical and mental health needs, and the impact of co-occurring disorders on child care; the need for systems change to incorporate services for women and children with co-occurring disorders; and that integrated services for mental health, substance abuse, and violence issues in a trauma-informed context appear to be more effective and not more costly than treatment-as-usual.

For an overview of the study, including contact information regarding the involvement of specific programs, refer to [http://www.wcdvs.com/pdfs/ProgramSummary.pdf.](http://www.wcdvs.com/pdfs/ProgramSummary.pdf)

*Source:* Becker and Gatz 2005; Salasin 2005

2000). The client learns to stop using unsafe coping mechanisms such as substance use and other self-destructive behaviors. An alliance between the counselor and the client, whose level of trust has been damaged by trauma, is the goal of this stage.

*Stage 2: Remembrance and mourning*

In this stage, women tell their stories of trauma. Women mourn the losses associated with their abuse and substance use (Hiebert-Murphy and Woytkiw 2000). More specifically, they mourn their old selves, which the trauma destroyed.

Women stabilized in substance abuse treatment may be ready to begin Stage 2 trauma work. A counselor can address the high risk of relapse that exists in this phase through anticipation,

planning, and self-soothing mechanisms

(Naj avits 2002b). Considerable clinical judgment is required in determining whether the client has adequate coping skills.

*Stage 3: Reconnection*

Once the woman has coped with past trauma, she can look to the future. Shelearns new coping skills, develops healthy relationships, and becomes oriented toward the future. Stage 3 groups, traditionally unstructured, can be comprised of both women and men. This phase corresponds to the ongoing recovery phase of substance abuse treatment. For some women, reconnection can occur only after years of working through trauma issues.

It is important to emphasize that the majority of clinical work surrounding trauma in substance abuse treatment programs and in early stages of recovery from substance use disorders should focus on safety, client skills **in** establishing safe behaviors, and early trauma recovery skills­ specifically coping skills such as grounding, emotional regulation, and stress management strategies.

***Note to Clinicians***

*Treatment programs and curricula* for substance use disorders and trauma

The following trauma-specific curricula are

designed to address treatment issues with women who have a history of trauma and trauma­ related symptoms and substance abuse. These programs are mainly focused on establishing safety and support, providing psychoeducation, and developing coping strategies and skills surrounding the sequelae of trauma and substance use disorders (for review of integrated trauma treatment models see Finkelstein et al.

2004 and Moses et al. 2003).

*The Addiction and Trauma Recovery Integration Model* (ATRIUM; Miller and Guidry 2001): Based on Miller's Trauma Reenactment Model, ATRIUM is a 12-week program that integrates psychoeducational and expressive activities for individuals with trauma-related and substance use problems. The ATRIUM model assesses and intervenes at the body, mind, and spiritual levels and addresses issues linked to trauma and substance abuse experiences

such as anxiety, sexuality/touch, self-harm, depression, anger, physical complaints

and ailments, sleep problems, relationship challenges, and spiritual disconnection.

*Beyond Trauma: A Healing Journey for Women and A Healing Journey: A Workbook for Women* (Covington 2003a, b): The theme of this 11-session integrated program for trauma treatment is the connection between substance abuse and trauma in women's lives. It includes a psychoeducational component for teaching

women about trauma and its effects on the inner self (thoughts, feelings, and beliefs) and the outer self (behavior and relationships, including parenting). The program emphasizes coping skills, cognitive-behavioral techniques, and

expressive arts, and is based on the principles of relational therapy. It includes a facilitator's manual, participant's workbook, and videos.

*Helping Women Recover: A Program for Treating Addiction* (Covington 2008a, *b* rev., 1999a, *b*): This 17-session step-by-step guide integrates the theoretical perspectives of substance abuse and dependence, women's psychological development, and trauma in four modules (self, relationships, sexuality, and spirituality). The program includes a facilitator's guide to work with such issues as self-esteem, sexism, family-of-origin, support system, mothering, and self-soothing issues. A Woman's Journal provides self-tests and exercises to help clients with substance use disorders create personal guides to recovery. There is a separate version for women in the criminal justice system (Covington, 2008a, *b* rev., 1999a, *b).*

*Seeking Safety* (Najavits 2000, 2002b, 2004, 2007): This manual-based, cognitive,

behavioral, and interpersonal therapy model for substance use disorders and PTSD focuses on client safety. It can be conducted in individual or group formats. The manual includes 25 topics and is based on five principles:

1. Safety as the priority of this "first stage" treatment
2. Integrated treatment of PTSD and substance use disorder
3. A focus on ideals
4. Four content areas: cognitive, behavioral, interpersonal, and case management
5. Attention to therapist processes

Several outcome studies have been completed on Seeking Safety, all showing positive results. The studies involve the following populations: women treated in an outpatient setting using a

Key issues in treatment for trauma-related mental disorders have been how, when, and whether to encourage clients to address trauma intensively during the course of substance abuse treatment. Most clinicians believe that a woman needs to achieve a basic level of safety before moving on to detailed trauma processing. The counselor should consider carefully the client's level of readiness for this type of work; the client's symptoms may worsen if she engages prematurely in such exploration (Herman 1997). In one study, interventions were adapted

to combine exposure therapy with the "Seeking Safety" program; clients with substance use disorders were encouraged to move in and out of trauma processing, balancing it with training in coping skills and building in specific safety parameters (Najavits et al. 2005).

***Note to Clinicians***

group modality (Najavits et al. 1998); women in prison in a group modality (Zlotnick et al. 2003); low-income and mostly minority women in individual format (Hien et al. 2004); adolescent girls (Najavits et al. 2006); and women in a community mental health setting in group

format (Holdcraft and Comtois 2002). In a study

that targeted patient and counselor feedback (Brown et al. 2007), results show that clinicians and clients alike were satisfied and felt that the Seeking Safety program was relevant to the treatment program and clients' needs. Seeking Safety has been implemented in a variety of clinical programs in addition to these research studies.

*Trauma Adaptive Recovery Group Education and Therapy* (TARGET; Ford et al. 2000): TARGET assists clients in replacing their stress responses with a positive approach to personal and relational empowerment. The curriculum includes a one- to three-session orientation, a five- to nine-session core education and skills curriculum, and 26 sessions of applications of recovery principles. TARGET has been adapted for clients who are deaf and for those whose primary language is Spanish or Dutch. TARGET is being evaluated in several treatment settings.

*Trauma Recovery and Empowerment Model* (TREM; Harris and The Community

Connections Trauma Work Group 1998): This 33-session group approach was developed by clinicians with considerable input from clients and includes survivor empowerment, power support, and techniques for self-soothing, boundary maintenance, and solving problems to be covered over 9 months. TREM assists women with the trauma recovery process and includes

social skills training, psychoeducational and psychodynamic techniques, and peer support groups. Each section includes discussion questions, typical responses, and experiential exercises (Harris and The Community Connections Trauma Work Group 1998). TREM is being evaluated in several treatment settings. Preliminary studies showed symptom reduction and client satisfaction (Berley and Miller 2004).

*Treating Addicted Survivors of Trauma* (Evans and Sullivan 1995): Combining therapeutic approaches with a 12-Step approach to the treatment of substance use disorders, this model for treatment of survivors of childhood abuse who have substance use disorders is based on

a medical view of substance abuse as illness. It assumes clients accept the 12-Step approach, uses the principle of safety first to drive all interventions, and has five stages to organize the selection and timing of treatment tactics: crisis, skills building, education, integration, and maintenance (Sullivan and Evans 1994).

*Substance Dependent PTSD Therapy* (SDPT; Triffleman 2000): This integrated approach showed positive outcomes in a small controlled pilot study that compared it with 12-Step facilitation therapy. SDPT is a 5-month,

two-phased, individual CBT method using relapse prevention and coping skills training, psychoeducation, stress inoculation training, and exposure treatment for PTSD. Participants meet twice weekly. The use of the combined approaches for PTSD treatment techniques with clients with substance use disorders is notable. The first phase incorporates understanding and education about PTSD symptoms as part of

the overall approach to abstinence. The second

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phase continues work on substance-related abstinence, while primarily targeting PTSD symptoms. In clinical trials, this model showed equal success rates in women and men.

**Mood Disorders**

##### *Depression*

Major depression is an intense, acute form of depression, often with physiological changes in such areas as sleep, appetite, energy level, and ability to think. Thought content includes feelings of worthlessness and suicidal ideation

or plans, although older adults and people from some ethnic groups or cultures sometimes do not express this cognitive component. Major depression has severe, moderate, and mild variants. Even mild major depression is a serious mental disorder.

Major depressive episodes and dysthymia are present in nearly twice as many women as men for both lifetime and 12-month prevalence.

Research suggests that women experience more chronicity of depression in comparison to men characterized by earlier onset of symptoms, poorer quality of life, greater social impairment, and greater familial history of mood disorders (Kornstein et al. 2000).

Although rates of depression among women of color in the general population are comparable with those for Caucasian women, the illness is more likely to be undiagnosed and untreated in the former group, according to the literature reviewed (Mazure et al. 2002). Depression may appear through somatic symptoms that are misinterpreted by providers. Of concern is the lack of compliance with treatment regimens using psychotropic medications by women of color, which is possibly related to side effects

of the medication. In addition, the sense of loss associated with migration may contribute to high levels of depression among Hispanic/Latina and Asian and Pacific-Islander immigrant women. In a study examining the use of pediatric emergency services with a sample of Mexican- and Central-American immigrants in Los Angeles, the women reported high levels of

mental distress (Zambrana et al. 1994). Somatic complaints are common among Hispanic/Latinas and can mask depression or other mental illness.

##### *Women with substance use* disorders and depression

Alcohol consumption and alcohol-related problems co-occur with depression more often in women than in men (Graham et al. 2007). Depression usually precedes alcohol abuse in women, whereas alcohol dependence usually comes first among men (Moscato et al. 1997). Two mechanisms have been suggested to explain the pattern among women: (1) alcohol is used to try to relieve the symptoms of depression, and

(2) depression renders women less concerned about issues of health and safety, including alcohol consumption (Dixit and Crum 2000). For more in-depth information on depression, refer to the TIP 48 *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery* (CSAT 2008).

One study indicates that the risk for heavy drinking is higher among women with a history of depressive disorder than among women

with no history of depression, and the risk for heavy drinking rises with increasing reports of depressive symptoms (Dixit and Crum 2000). Research suggests that genetic factors contribute to women's susceptibility to both disorders.

Among treatment-seeking women, depression is positively correlated with craving (Zilberman et al. 2003). While craving is not consistently associated with relapse, clients who experience

cravings express distress in managing and coping with them.

Although it may be difficult to determine whether the depression or substance use disorder is primary, both need to be identified and treated concurrently to minimize relapse and improve a client's quality of life. If a woman's depression is life threatening, the depression must be treated immediately. In general, the disorder with the higher crisis potential needs to be addressed first-but neither should be neglected. Withdrawal symptoms sometimes include depression,

and withdrawal symptoms sometimes mask depression. Appropriate treatment requires a thorough history and monitoring of symptoms over time.

*Substance abuse treatment and* depression

Women with co-occurring substance use

disorders and depression can be placed in a variety of treatment settings, depending on the severity of their disorders. Antidepressant and mood-regulating medications are appropriate for women in treatment for both disorders.

Clients may require medication to overcome debilitating and incapacitating depressive symptoms so that they can participate in substance abuse treatment. In addition, relief from depression can be significant motivation in recovery. However, it may take time for a client to be stabilized on the appropriate medication and dosage. Women may need education and medication monitoring initially to ensure they are taking their medications as prescribed. Some women may increase their dose thinking that the larger dose provides more help or reduce their dose to prove they are improving. Still other women may have difficulty taking antidepressant medication based upon fear and misinformation that it is addictive.

SSRis and other new generation antidepressants often are used because their improved side effect profile increases the likelihood of compliance (Zweben 1996). Women with depression may respond to a combination of psychotherapy and medication. CBT and interpersonal therapies (IPT) are evidence-based approaches in treating depression (Butler et al. 2006; deMello et

al. 2005; Kuyken et al. 2007), and they can be used as an adjunct to medication or as a principal intervention for mild or moderate

depression. For clients who are hesitant to use medications or when the use of medication is contraindicated, CBT and IPT are viable options but appear far less effective when

depression is severe (Luty et al. 2007; Markowitz 2003).

Eating Disorders

Between 90 and 95 percent of those diagnosed with eating disorders are women (Hoek 1995), with as many as 5 percent of young women being affected (Frank et al. 1998). Studies have shown that bulimia affects between 2 and 5 percent of women, whereas anorexia is much less common (Frank et al. 1998). About 2 percent of the U.S. population has a binge eating disorder, and it occurs in 10 to 15 percent of mildly obese people (National Institute of Diabetes and Digestive

and Kidney Diseases 2001). However, all measures of the prevalence of eating disorders are considered to be estimates by researchers because they represent only cases diagnosed in medical facilities. Women with eating disorders are skilled at concealing their disorders and many remain undiagnosed (Hoek and Van Hseken 2003). Common definitions of eating disorders and behaviors are defined in

Figure 7-4.

Substance abuse counselors and mental health professionals have difficulty detecting eating disorders because clients minimize or deny their symptoms and fail to seek treatment out of shame or fear of gaining weight. Counselors should be alert to symptoms of eating disorders that mayhe serious hut do not meet full criteria for an eating disorder diagnosis. Disordered eating behaviors can pose serious health issues and lead to full-blown disorders. In addition,

counselors should he aware that eating disorders occur in women from diverse backgrounds.

Women receiving methadone maintenance treatment **(MMT)** require antidepressant medication that is compatible with methadone, but dosages of both need close monitoring. Although MMT can normalize mood in some women, it is a treatment for opioid dependence, not depression (Zweben 1996). TIP 43 Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs (CSAT 2005b), provides more information.

***Note to Clinicians***

***Figure 7-4 Common Definitions of Eating Disorders and Behaviors***

*Anorexia nervosa* is self-starvation. Women with this disorder eat very little even though they are thin. They have an intense and overpowering fear of body fat and weight gain.

*Bulimia nervosa* is characterized by cycles of binge eating and purging, by either vomiting or taking laxatives or diuretics (water pills). People with bulimia have a fear of body fat even though their size and weight may be normal.

*Overexercising* is exercising compulsively for long periods to burn calories from food that has just been eaten. Women with anorexia or bulimia may overexercise.

*Binge eating* means eating large amounts of food in short periods, usually when alone, without being able to stop when full. The overeating or bingeing often is accompanied by feeling out of control and is followed by feelings of depression, guilt, or disgust.

*Disordered eating* refers to troublesome eating behaviors, such as restrictive dieting, bingeing, or purging, which occur less frequently or are less severe than those required to meet the full criteria for the eating disorder diagnosis.

*Source:* Adapted from HHS, Office on Women's Health *2000b.*

Although anorexia is seen most often in young heterosexual Caucasian women, girls and women from all ethnic and racial groups have eating disorders and disordered eating at increasing rates. Often these women receive treatment

for the accompanying symptoms of an eating disorder, such as depression, rather than for the disorder itself. When they are finally

diagnosed, the disorder tends to be more severe (HHS, Office on Women's Health 2000). Overall, studies show that eating disorders are positively associated with all DSM-IV mood, anxiety, impulse-control, and substance use disorders regardless of age, gender, and race-ethnicity (Hudson et al. 2007).

*Women with substance use and* eating disorders

One study evaluating the role of eating disorder

behaviors and its association with substance use (Piran and Robinson 2006) determined that as eating disorder behavior becomes more severe, the number of substance classes used increases as well. Specifically, severe bingeing was consistently associated with alcohol consumption, and dieting and purging was associated with stimulant and sleeping pills/

sedative use. Herzog and colleagues found that 17 percent of women seeking treatment for either anorexia nervosa or bulimia nervosa had a lifetime drug use disorder (Herzog et al. 2006).

Overall, research indicates that substance abuse is accompanied more often by bulimia and bulimic behaviors than by anorexia (Bulik et

al. 2004; Holderness et al. 1994; Ross-Durow and Boyd 2000). Nearly one third of women with a history of bulimia also have a history of alcohol abuse, and 13 percent have a history of alcohol dependence. Alcohol abuse and dependence have been found to be related to PTSD and major depressive disorder, which in turn were associated with bulimia. One study demonstrated that alcohol use disorders are highly prevalent among women with bulimia and that the presence of PTSD and depression

increases the risk of alcohol abuse occurring (Dansky et al. 2000).

Attitudes toward dieting among young women may be related to increased susceptibility to alcohol and drug use (Zweben 1996). This is both a health issue and a relapse risk because some women may use cocaine or amphetamines (or both) to manage their weight. Additionally, the tendency to overeat affects many women in

early recovery. Compulsive or binge eating bears a similarity to abuse of substances other than food and is correlated with depression, thoughts of suicide, and childhood sexual abuse. Women engaging in binge eating sometimes use food as

a substitute addiction; others may overeat to compensate for the stress they experience in early abstinence. Elements of the eating disorder take the place of relapsing to the drug of choice (Ross 1993).

Eating disorders need to be viewed in a biopsychosocial context that addresses biological or organic factors, a social component (influence of media and other cultural images enforcing standards of slimness for women),

and psychological issues. Eating disorders are correlated with growing up in dysfunctional families where substance abuse occurs (van Wormer and Askew 1997). A strong relationship exists between eating disorders and depression, self-inflicted violence, and suicidal tendencies (APA *2000a;* Kuba and Hanchey 1991). Most women with eating disorders meet DSM-IV criteria for at least one personality disorder, such as borderline, histrionic, or obsessive­ compulsive personality (Zerbe 1993).

Eating disorders are sometimes present before the onset of alcohol and drug problems and can be obscured by active substance use, or they may be inactive during periods of active drinking or drug abuse. Eating disorders can precede the onset of substance use disorders chronologically, follow them, or develop simultaneously (Bulik and Sullivan 1998). A history of bulimia, anorexia, or compulsive overeating could become a barrier to the successful treatment of a client's substance use disorder if the prior eating disorder goes

undetected. Deprived of compulsive involvement with food, a woman may begin to abuse substances. During treatment for substance use, unbeknownst to the therapist, the disordered eating behavior may reappear. Because the eating disorder takes over the function of the substances by helping the client cope, a cycle

can occur that never addresses the common and predisposing factors contributing to both problems. There may be success in that the substance use has stopped; however, this may

be a result only of disordered eating or symptom substitution. This disordered use of food masks depression, anxiety, and other symptoms expected to surface during the treatment of substance use, leaving the therapist with no view of the woman's coping abilities without any compulsive and disordered behavior. Eating disorders may coexist with alcohol and drug consumption in other ways (John et al. 2006).

Diuretics, laxatives, emetics, stimulants, heroin, tobacco, and thyroid hormone may be attractive to a woman with anorexia or bulimia because

of their weight-loss potential or their ability to facilitate vomiting (Bulik and Sullivan 1998).

##### *Substance abuse treatment and* eating disorders

Therapeutic modalities include individual, group, and family therapies. A cognitive­ behavioral approach is used to address the irrational thoughts that lead to disordered eating behaviors (van Wormer and Askew 1997). CBT has been effective for women with

bulimia in reducing the frequency of binge/purge cycles and improving body image, mood, and social functioning. In some instances, the use of tricyclic antidepressants and selective serotonin reuptake inhibitors can improve short-term outcomes, but in all eating disorder cases, medical evaluation should be included (Carr and McNulty 2006; Raeburn 2002).

Interpersonal therapy has been used successfully with women with bulimia, and dialectical behavior therapy recently has begun to be used with this population (Raeburn

2002; Safer et al. 2001). Additional treatment approaches for women with eating disorders that can engage clients include psychoeducation, behavioral contracting, and nutrition monitoring (Frank et al. 1998).

Treating this condition requires specialized training, along with a thorough medical evaluation for problems typically associated with eating disorders. Clients require nutritional counseling to develop healthful eating patterns, medications (usually antidepressants), and discharge planning that addresses both eating and substance use disorders (Marcus and Katz 1990). Eating disorders often surface or are exacerbated when women reduce substance

use; in this situation, integrated care and management is the optimal choice.

It is important for counselors to look beyond the earlier profiles of eating disorder cases and consider symptoms among women of color and in various social classes. The HHS Office on Women's Health provides educational materials on eating disorders on its Web site ([www.4women.gov/Bodylmage).](http://www.4women.gov/Bodylmage))

**Addressing Tobacco Use With Women in Treatment**

Cigarette smoking is a major cause of lung cancer among women. Approximately 90 percent of all lung cancer deaths are attributable to smoking. Since 1950, lung cancer mortality

rates for American women have increased an estimated 600 percent. In 1987, lung cancer surpassed breast cancer to become the leading cause of cancer death among American women. In 2000, about 27,000 more women died of lung cancer (67,600) than breast cancer (40,800; CDC 2001). In 2004, diseases caused by cigarette smoking killed an estimated 178,000 women **in** the United States. The three leading diseases were lung cancer (45,000), chronic lung disease (42,000), and heart disease (40,000; CDC 2005).

Although it is commonly accepted in the substance abuse treatment field that the useof one addictive drug frequently leads to relapse

***Advice to Clinicians:***

###### Women With Eating Disorders

Substance abuse counselors may want to consider these steps in addressing eating disorders:

* Include an eating history as part of a comprehensive assessment of a client (refer to chapter 4 on Screening and Assessment).
* Refer for medical evaluation.
* Ask the client what happens as a result of the disordered eating behaviors. Does she feel in control, more relaxed, or numb? Approach eating disorders as a response to emotional discomfort.
* Educate the client about eating behaviors as a legitimate health concern.
* Develop integrated services, and coordinate necessary services and referrals (including a referral to a provider that specializes in eating disorder treatment).
* Incorporate nutritional counseling and psychoeducation on eating disorders and disordered eating.
* Institute routine observations at and between meals for disordered eating behaviors.
* Recommend the use of support groups that are designed specifically for the given eating disorder.
* Teach coping skills using cognitive-behavioral therapy and include anxiety management training.

*Source:* Bulik and Sullivan 1998; Rome 2003

to a person's "drug of choice," this has not been clarified in the issue of nicotine use and substance abuse (Burling et al. 2001). Many treatment professionals have thought it too difficult for clients to give up tobacco and still remain abstinent from other substances even after years of being drug or alcohol free. They believed that any attempt to stop smoking could put the recovering person at an increased risk for relapse. It also was assumed that people will quit naturally if they so desire (Bobo et al. 1986).

However, research and experience since the mid- 1980s has begun to challenge these assumptions (for review, see Prochaska et al. 2004; Sussman 2002). Research shows that quitting smoking does not jeopardize substance abuse recovery; that nicotine cessation interventions in substance abuse treatment are associated with an increase in long-term abstinence of alcohol and illicit drugs. Prochaska and colleagues (2004) examined outcomes of smoking cessation interventions in 19 randomized controlled

trials with individuals both in current addiction treatment and in recovery. The researchers found striking interactions between smoking cessation and success in treatment for other drug abuse. Their first observation was that among both men and women, those who stopped smoking while also quitting other drug use showed higher success rates in abstinence from alcohol and other drugs, even though their rates of relapse to cigarette use was high.

Motivating women to stop smoking involves addressing their concerns about the difficulties and negative consequences of smoking cessation and bolstering their confidence to stop (Miller and Rollnick 2002). Women's motives for stopping smoking include their present health, their future health, and the effect of their smoking on the health of others. Women's concerns about quitting include believing stopping will be difficult, feeling tense and irritable if they quit, enjoying smoking too much to stop, expecting difficulty concentrating after quitting, and anticipating gaining considerable weight after stopping (Lando et al. 1991; Pomerleau et al. 2001). Studies have not

consistently shown differences in relapse rates between men and women, yet women appear to have higher rates of relapse when they fail to adhere to pre-established quit dates (Borrelli et al. 2004). Among women, relapse is significantly related to weight gain, strong negative affect, history of depression, family history of smoking, unemployment, and a history of smoking cigarettes high in nicotine (Cooley et al. 2006; Hoffman et al. 2001; Swan and Denk 1987; Wetter et al. 1999).

Akin to other services, smoking cessation programs should be integrated into substance abuse treatment for women. Providers are encouraged to include smoking cessation in their clients' treatment plans, as this will help send

a message to women that treatment providers care about their total health. Further, even temporary cessation from smoking (assisted with nicotine replacement therapy) may give women confidence about remaining abstinent from other substances, and there may be no other opportunity to help them quit smoking. In reviewing the common relapse risks among women, nicotine cessation programs should consider strategies (along with pharmacologic

therapies), that address body image, nutritional counseling, and emotional regulation combined with CBTs that target cognitions, establish

quit dates, and teach coping strategies to manage anticipated difficulties in maintaining abstinence.

The consensus panel believes that smoking cessation programs should be offered in all substance abuse treatment programs. Clinics can meet a minimum standard of care by adopting some of the following guidelines:

* Require all treatment facilities to be smoke free, and provide nicotine cessation programs for employees as well.
* Provide onsite cessation services and include tobacco and nicotine issues as part of treatment planning.
* Train staff to address nicotine addiction. Substance abuse counseling skills already in place can he applied to help clients achieve and maintain smoking cessation.
  + Base counseling sessions on professional guidelines for smoking cessation, such as those supported by the National Cancer Institute and the U.S. Public Health Service.
  + Provide all clients access to pharmacotherapy as an aid in quitting tobacco use; for example, nicotine patches and nasal sprays, bupropion (ZybanTM), and varenicline (ChantixTM), if medically appropriate. Note that few studies have examined the risks

associated with nicotine replacement and other pharmacotherapies among pregnant women (for review, see Schnoll et al. 2007; Wise and Correia 2008).

* Identify local resources for referrals for more intensive interventions, such as the American Cancer Society (www.cancer.org) and the American Heart Association ([www.](http://www/) americanheart. org).

## 8 Recovery Management and Administrative Considerations

#### Overview

**In This Chapter**

Continuing Care

Treatment Outcome

Support Systems for Women

Administrative Considerations

The first part of this chapter, aimed at the substance abuse treatment counselor, examines the most critical aspects of re­ covery management including continuing care services, outcome and relapse variables, and support services. The second part

is directed toward substance abuse treatment program admin­ istrators and supervisors. This segment looks at the benefits of consumer participation in programming, the characteristics of a healing environment for treatment, and the main components of staff development including staffing, training, and clinical supervision specific to women's programming. Organizational change strategies that focus on how an organization can become gender responsive follow.

#### Continuing Care

Continuing care services, often referred to as aftercare, are substance abuse services that occur after initial treatment. Continuing care is designed to provide less intensive services as the client progresses in treatment and establishes greater duration of abstinence. The dearth of research on continuing care is particularly evident surrounding gender differences. Several studies are available that show potential patterns, but caution is needed in interpreting the findings due to methodological issues and sample size.

Although women appear more likely to attend aftercare, any transition from one service to the next can be challenging for the client and treatment provider (Carter et al. 2008). In general, clients are more likely to discontinue treatment during these periods. Women

often express feelings of disconnection with the new treatment provider and experience additional struggles in managing the added demands and expectations of child care while attending less intensive treatment. Relapse is

more prevalent during these periods, especially when there is little compliance or support from family to follow aftercare plans. The initial risk factors that served as a direct or indirect path to substance use often are the same risk factors that reappear in early recovery and sabotage involvement in continuing care, recovery activities, and abstinence. As an example, women who have a history of substance use that involves a significant relationship appear

more likely to leave care prematurely due to the influence of a boyfriend, spouse, or significant other.

In one study that gained information from program case managers, it was reported that the women who had prior inadequate drug treatment services were most likely to drop out of continuing services (Coughey et al. 1998).

Those women who completed aftercare had two times the amount of prior residential alcohol/ drug treatment and longer sobriety time at admission. Equally important, women appear more likely to engage in continuing care if

the primary treatment they received involved specialized programming for women (Claus et al. 2007).

#### Treatment Outcome

Historically, researchers have used posttreatment abstinence rates as the focal point of measuring success. Debate has ensued regarding how to measure treatment outcome and whether or not posttreatment abstinence rates are myopic in that they fail to account for the physical, psychological, and social conditions that improve in the treatment process. Other commentaries have suggested that using abstinence rates as the only benchmark to measure outcome falls short of recognizing the chronic nature of

substance dependence disorders-that relapse is not inevitable but a likely event that can

provide a client with a learning opportunity to strengthen recovery skills. Overall, most

outcome studies have targeted more immediate responses to treatment, often measuring and following outcome variables no longer than 12 months beyond discharge (Grella et al. 2005). This section examines the many factors that contribute to treatment outcome and includes numerous studies that expand the definition

of treatment outcome beyond abstinence rates, including quality of life and other biopsychosocial benefits. The segment ends

with a discussion on relapse and prevention for women, and specifically for postpartum women.

Gender is not a significant predictor of treatment outcome. Once in treatment, women are as likely as men to complete treatment

and have good treatment outcomes, although outcome differences are noted when evaluating individual and program characteristics

(for a comprehensive literature review, see Greenfield et al. 2007a). Women are also as likely to have similar abstinence rates and overall quality of life 1 year after discharge from treatment (Slaymaker and Owen 2006). As shown by previous research (Timko et al. 2002), women show greater increases than men in employment, recovery-oriented social support systems, and participation in self- help groups (Grella et al. 2005). Grella's study found that women have greater reduction

in levels of distress, although their levels of distress appear to remain consistently higher than those of their male counterparts at each period of outcome evaluation. For women with posttraumatic stress reactions, literature supports the relationship between the receipt of integrated trauma treatment services and positive treatment outcome (Cohen and Hien 2006; Cocozza et al. 2005). In a posttreatment

outcome study measuring factors that predicted 5-year abstinence, 12-Step participation and involvement in social networks that support recovery were among the essential ingredients (Weisner et al. *2003a, b).*

Although further evaluation is needed, there appears to be a stronger association between treatment participation and posttreatment outcome among women (Fiorentine et al. 1997;

Hser et al. 2004). Literature suggests that treatment completion and length of stay in residential treatment are important factors in establishing positive posttreatment outcomes among women (Greenfield et al. 2004). Specific posttreatment outcome analysis comparing length of treatment to posttreatment outcome in residential treatment for pregnant and parenting women and their children shows an association between longer lengths of stay and abstinence, improvements in employment and income, decreases in arrests and depressive symptoms, and more positive attitudes toward parenting (Conners et al. 2006). Although studies have begun to shed light on gender differences in posttreatment outcome, future research should continue to examine the specific underlying factors that influence treatment outcomes

and how these factors differ between men and won1en.

Relapse

Gender alone does not predict substance abuse treatment outcomes. Instead, client characteristics are more likely to predict

relapse, and these characteristics often influence the risk of relapse differently in men and women (Greenfield et al. 2007b). Women who complete treatment for substance use disorders show

no significant differences in relapse rates or only slightly better outcomes compared with men (for review, see Walitzer and Dearing

2006). However, gender differences do emerge across qualitative and quantitative studies that evaluate antecedents or risk factors associated with relapse and the clients' psychological and behavioral reactions to the relapse. Relapse characteristics and reactions specific to

women are highlighted in Figure 8-1 (p. 184).

Women are as likely as men to experience positive treatment outcomes including similar abstinence rates and overall improvement in quality of life.

Currently, many relapse prevention programs

do not delineate specific strategies and therapeutic approaches for women. Thus, research is needed

to develop and evaluate relapse prevention programs and intervention strategies for women. One randomized study is available that evaluates a manual-based, women-only, women­ oriented relapse prevention therapy group called Women's Recovery Group (WRG). In this study, WRG produced better outcomes in the 6 months following treatment than a mix-gender group using a standard manual-based program

(Greenfield et al. 2007b). A forthcoming book by Greenfield, to be published by Guildford Press,

The ability to regain custody of children can significantly motivate mothers to not only enter and pursue treatment but also to maintain motivation for ongoing recovery after treatment. Mothers in early recovery can face numerous challenges and stressors associated with reunification, including time pressures in establishing recovery to avoid termination of parental rights, the maintenance of recovery activities while assuming the parenting role, the management of affect associated with the impact of their past drug and alcohol use on their children's physical and mental health, effective implementation of parenting skills, and others (for review, see Carlson et al. 2006). As a provider, it is important to not only acknowledge the mother's initial enthusiasm and motivation for reunification, but also incorporate preparatory skills, including parenting, stress and anger management, and problemsolving to help fortify personal resources in anticipation of future parenting and childcare issues and challenges.

***Note to Clinicians:***

**Family Reunification**

will provide the protocol for this women-specific relapse prevention group. Figure 8-2 provides examples of topics discussed in WRG.

*Postpartum relapse prevention*

It is not uncommon for women who abstained from alcohol, drugs, and tobacco during pregnancy to return to use after childbirth (Mullen 2004). The stresses of parenting a newborn and the resumption of activities curtailed during pregnancy can involve a host of triggers. The postpartum period presents numerous triggers for relapse in recovering women who are drug dependent, including:

* + Pain and other common discomforts of the postpartum period.
* Fatigue and sleep deprivation.
* Other chronic health problems.
* The stress of role adaptation and caring for a newborn (along with other children for some women).
* Shifts in relationships with partners and family members.
* Interactions with child welfare agencies, courts, and criminal justice agencies.
* Ambivalence about parenting.
* Temporary or permanent loss of custody, whether voluntary or involuntary.
* Reunification after temporary loss of infant custody.
* Guilt and grief related to infant illness or death.
* Other stressors of daily living.

*Figure 8-1* Women-Specific Predictors of Relapse and Reactions to *Relapse*

**Relapse Risks Unique to Women**

Women are more likely to relapse if they report or display:

* + Interpersonal problems and conflicts.
  + Low self-worth that is connected to intimate relationships.
  + Severe untreated childhood trauma.
  + Strong negative affect.
  + More symptoms of depression.
  + Greater difficulty in severing ties with other people who use.
  + Failure to establish a new network of friends.
  + Lack of relapse prevention coping skills.

**Women's Reactions to Relapse**

Women are more likely than men to exhibit the following behaviors during or after relapse:

* + Relapsing in the company of others and particularly with female friends or a significant other.
  + Escalating use after initial relapse that is positively associated with severity of childhood trauma.
  + Seeking help.
  + Experiencing slightly shorter relapse episodes.
  + Reporting depressed mood.

Women are less likely than men to be affected by the same relapse risks across multiple relapse episodes.

*Source:* Coyne et al. 2006; Hyman et al. 2007; McKay et al. 1996; Project MATCH 1997; Rubin et al. 1996; Sun 2007; Zywiak et al. 2006.

*Figure 8-2* Women's Recovery Group: Manual-Based Relapse Prevention

**Group Format:** 90-minute sessions

* + Brief check-in
  + Review of past week's skill practice
  + Presentation on session topic
  + Open discussion of topic and other recovery-related issues
  + Review of session's "take-home message" and upcoming week's skill practice
  + Check-out

**Content Areas:**

* + The effect of drugs and alcohol on women's health
  + What are the obstacles to seeking treatment and getting into recovery?
  + Managing mood, anxiety, and eating problems without using substances
  + Violence and abuse: Getting help
  + Women and their partners: The effect on the recovery process
  + Women as caretakers: Can you care for yourself while taking care of others?
  + Women's use of substances through the life cycle
  + Substance use and women's reproductive health
  + The issue of disclosure: To tell or not to tell
  + How to manage triggers and high risk situations
  + Using self-help groups to help yourself
  + Can I have fun and not use drugs or alcohol?
  + Coping with stress
  + Achieving balance in your life

*Sonrce:* Greenfield et al. 2007b

Relapse prevention education with emphasis on postpartum triggers will help women anticipate and plan for such triggers. Relapse prevention techniques are often taught in groups using structured curricula that include strategies for maintenance of abstinence and recovery, such as identifying high risk situations; learning refusal skills that can be practiced with peers and staff in advance of "real life" challenges; and recognizing triggers that lead to relapse thinking, drug craving, and eventual use.

Although there are multiple new demands placed on recovering postpartum women, using the tools for relapse prevention in the context of a

full program of recovery activities is essential for continued abstinence.

During treatment, triggers for drug use should be identified and explored with recovering women prior to program discharge in concert with individualized treatment planning. Many of the services and resources used by the client prenatally should be continued, if not

intensified, in the postpartum period. Alumnae groups and in-home visitation programs

have assisted women with relapse prevention and family preservation (French et al. 2007; Gruber et al. 2001). Drug-specific research on postpartum women and relapse has primarily examined relapse to smoking after childbirth. In one study, correlates of postpartum relapse to smoking included high maternal weight gain, late or no prenatal care, and stressful

***Advice to Clinicians:***

**Postpartum Relapse Prevention**

* Pregnancy issues must always be fully addressed within a set of comprehensive treatment plans, including postpartum relapse prevention.
* Relapse prevention following delivery is especially critical as many clients "quit for the baby" and not themselves and thus are susceptible to resume use.
* The postpartum period is saturated with stresses and triggers for relapse, and each must be addressed in the client's relapse prevention plan.

life events (Carmichael and Ahluwalia 2000). Other research suggests that postpartum women relapsed to smoking in order to manage emotions, stress, and weight, and because they did not initially quit for themselves (Bottorff

et al. 2000; Levine and Marcus 2004). Relapse prevention programs for postpartum women who smoke can decrease future smoking in some of these women (Ratner et al. 2000).

For many perinatal women who are monitored by drug courts, probation, parole, and child welfare agencies, the consequences of relapse can be devastating in terms of the potential for loss of child custody. Perinatal programs, in acknowledgment of the importance of parenting roles and relationships to women, recognize the possibility of relapse and acknowledge that this is the time when assistance to the client and her child should be intensified, not eliminated.

#### Support Systems for Women

Twelve-Step recovery groups have been a vital resource for over 50 years, and as time has evolved, more women have participated in these recovery support groups. Originally, the Alcoholics Anonymous (AA) program was written by men and primarily for men, and

the content and language reflected this bias-a bias that was steeped in the culture of the time period in which it was written. The AA literature has since been revised and updated, yet issues regarding sensitivity to language and the limited focus on cultural and social issues pertinent to women's dependence and recovery remain a

potential roadblock for some women (Covington 1994). Nonetheless, 12-Step support groups have been the most steadfast peer-facilitated program, providing women a viable avenue of support in establishing abstinence, in developing recovery skills, and in maintaining recovery.

Most research on the effectiveness of 12-Step groups has been conducted with men, but some studies have examined gender differences. To date, research results reflect inconsistencies regarding differences in attendance and abstinence rates between men and women.

Moos, Moos, and Timko (2006) found that women appeared to gain even greater benefits from AA than men, and women were more likely to attend AA and to attend more frequently.

Compared with men, women showed less avoidance coping and greater reduction in depression with continued AA participation. Another study reported no gender differences in 12-Step attendance over a 24-month period, including frequency of participation and drop­ out rates (Hillhouse and Fiorentine 2001). For women, availability of support and sponsorship appear to be the main ingredients in perceived

social support in 12-Step recovery groups (Rush 2002).

Like men, women have other options for support group involvement. Women for Sobriety is the only self-help program designed specifically for women who are alcohol-dependent. Although women can benefit from participation in groups and from the supporting women-centered literature, availability of support groups is limited. To date, gender-specific outcome research on recovery groups outside of 12-Step programs is minimal.

#### Administrative Considerations

###### Consumer Direction, Participation, and Empowerment

The field of substance abuse treatment has a tradition of integrating consumers into service delivery as counselors and case managers, particularly at the direct service level. However, the field is only beginning to learn about and apply the enormous benefits received when these individuals are integrated into the entire fabric of service delivery, from program design to implementation and evaluation. For example, the SAMHSA-funded Women, Co-Occurring Disorders and Violence Study demonstrated a priority on including consumers in all aspects of

study design and implementation throughout the 5 years of the study.

Prescott (2001) identifies the important contributions made to service systems and research when consumers are actively involved. When hiring people in recovery as mentors, case managers, counselors, and board members, characteristics to consider include significant time in recovery, ability to handle the expected range of tasks, and considerable training

in issues related to recovery in the specific treatment areas (Moses et al. 2004).

Service system benefits include:

* Improving quality of services and systems.
* Contributing to systems knowledge.
* Improving customer orientation.
* Positively affecting policy development.
* Adding diversity.
* Reducing stigma.
* Providing positive role models.
* Promoting increased awareness and education among coworkers.
* Providing knowledge about and linkages to community and alternative resources.
* Increasing client engagement and retention.

Research benefits include:

* Enhancing research design.
* Promoting engagement of research subjects.
* Broadening interpretations and perspectives of research findings.
* Increasing research relevance (Prescott 2001,

p. 6).

Active involvement of consumers in all aspects of treatment planning significantly contributes to both recovery and empowerment, and

is essential if meaningful, effective services for women and children are to be developed (Schauer et al. 2007). The consensus panel believes consumers should have input into program design as well as management and research evaluation protocols. In addition, training in leadership and advocacy for

consumers contributes to their feeling of being part of a group, effecting changes in their lives and communities, learning skills, changing others' perception of their competencies, increasing their positive self-images, and overcoming stigma. These elements are critical components of empowerment (Chamberlin and Schene 1997).

Prescott (2001) lists the benefits to recovering women involved in programs:

* *Positive role model.* Consumers are positive role models when they serve in capacities ranging from chief executive officer to support staff. Women who volunteer at the treatment program or in the community can be positive role models for clients new to treatment.
* *Promotion of specific skills.* As staff members in a treatment program, consumers learn skills to help themselves communicate with community agencies and social service groups and learn how organizations change and ideas are implemented, thereby gaining a sense of control over the environment.
* *Promotion of recovery and well-being.* Being a part of the treatment milieu, having responsibility for an aspect of the program, and working **with** colleagues whose mission is to promote wellness can help a woman focus her life on maintaining her health and recovery.
* *Increased sense of hope.* The increased security of having employment and perhaps income helps consumers envision their future in a more promising light.
  + *Cultivation of self-efficacy.* As consumers acquire the skills they need to make positive contributions to the work of the treatment program, their belief grows in their abilities to handle problems on a broad scale.
  + *Decreased stigma.* When consumers play a role in a treatment program, they give evidence that substance abuse is not a

character flaw or moral defect but an illness that can be overcome. Their presence sends that message to others and mitigates any internalized stigma of consumers.

Consumer-centered programs incorporate the views of women in recovery in all stages of

program design, management, and evaluation. In this way, the quality of services and systems integration improves, coworkers become better educated about the process of recovery, and the stigma of substance abuse is reduced.

Creating a Healing Environment

The primary characteristic of a healing environment is safety. The environment should also be holistic, seamless, and centered on

a woman's needs. To promote healing, the therapeutic environment must be inviting and welcoming, with culturally appropriate

decorations and pictures. Surroundings should be multicultural, highlighting heroines from many cultures. A connection to women's history and female heroes plays an important role in bolstering women's self-efficacy.

In both residential and outpatient programs, the physical layout must provide privacy and

space where women can be quiet and meditative. Private time is needed in their schedules; treatment programs can offer an array of services that pack a daily schedule, **but** women need

time for contemplation and to pursue personal interests. Music and recreational activities should be available. Space dedicated to child care and equipment for children's activities is essential if children are included in the program.

In women's treatment programs, sensitivity to trauma-related issues is critical to a healing environment. A calm atmosphere that respects privacy and maximizes client choices promotes

healing. Staff should be trained to recognize the effects of trauma, and women should have a clear understanding of the rules and policies of the residence. A trauma-informed environment must consider:

* Attention to safety.
* Attention to boundaries between staff and participants, among participants, and between participants and visitors (e.g., giving women permission to say no to hugging; hugging can be a common expression of positive emotion for some women, **but** for those who have been traumatized it could represent an undesired intrusion into their personal space).
* Mutuality in staff-staff and staff-client relationships.
* A nonpunitive atmosphere in which conflict is addressed by negotiation to the extent possible.
* An organizational structure that allows participants access to several layers of staff and administrators.
* Encouragement of assertiveness and leadership.
* Self-care.

Staffing

A woman-centered staff member is an active participant in treatment and considers the specific needs of women in general and of each particular client and how they can be addressed. She weighs the realities and complexities of women's lives and their social and gender

roles with a nonjudgmental attitude. Although programs are not always able to hire a woman for each staff position, a program still can adhere to a woman-centered philosophy. A

key rationale for having female staff work with female clients is role modeling; people watch more than they listen. A woman-run program shows clients how women can exercise power effectively. Women need to be seen in leadership roles in the program.

This goal does not, however, exclude men as treatment providers for female clients; men who are respectful of women's experiences can help women. They must have a woman­ centered perspective and be knowledgeable about women's issues, particularly trauma

and domestic violence. In residential programs or other programs with children's services, male staff members can play a valuable role by being healthy male role models for women

and their children. Women report that working with a male counselor who is compassionate and respectful can be a healing experience, particularly if they endured negative

relationships with men. Ideally, a woman should have the option to choose either a man or a woman as her primary counselor.

Men can serve in a variety of roles in nonresidential programs, including case manager, housing coordinator, couples' or children's counselor, and general equivalency diploma teacher. They can provide a male point of view about parenting and assist in exploring the attitudes and behavior of the clients' partners.

Training

Treatment providers and staff members at all entry points in systems that serve women

need to be able to screen, triage, and refer for substance abuse treatment using an approach that supports and encourages women to receive treatment. Because of a lack of knowledge about substance use generally and about women particularly, as well as the tremendous stigma attached to women who abuse substances, it

is important that all staff training include a process that identifies, acknowledges, and brings to awareness the biases, judgments, and anger toward women who use and abuse substances.

The pervasiveness of substance use and abuse and the negative effect it has on the lives of

so many people make it difficult to remain objective as a helping professional. If women are to be identified and referred when in need of treatment for their substance use, those in a position to help must be able to interact in a manner that assists and causes no harm.

*Training for point-of-entry* providers

Point-of-entry providers see women with a variety of complaints and have the potential to identify and refer women for assessment and treatment. These point-of-entry providers

include those in healthcare, domestic violence, social service, child protection, mental health systems; schools and daycare centers; the criminal justice system; TANF (Temporary Assistance for Needy Families) workers, judges, and clergy. The consensus panel recommends that because these providers

are in the position to identify women in need of substance abuse treatment, a minimum standard of cross-training among systems and

within interdisciplinary groups is needed. With a heightened focus on cultural and linguistic competency, along with substance abuse education, training can help practitioners avoid creating barriers to treatment when clients are from cultures, ethnicities, or sexual orientations different from their own (Goode et al. 2006).

Figure 8-3 defines the attitudes, skills, and knowledge that should be the goals for training an audience of point-of-entry staff.

*Training for substance abuse* treatment counselors

Although it is widely assumed that clinical

staff members who provide substance abuse treatment are prepared to serve both men and women, the training received by clinicians does not always specifically include women-centered treatment. The consensus panel believes

that training for clinicians should include information on the psychological growth and development of women, cultural competence, sexual orientation and gender identity issues, the role of relationships in women's development of a sense of self, the importance of children in the treatment process, children's importance in the lives of mothers, and the sense of adequacy in parenting that is vital to self-esteem. Training should include information on the etiology of

use and abuse of substances in women and the physiological effects that are unique to women. Counselors also need to be able to disseminate accurate information about the bodily changes and potential effects of substance use on both a pregnant woman and her fetus.

In addition, social roles and status in society strongly influence the patterns, consequences, and context of use, as well as the treatment

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| ***Figure 8-3 Goals and Training Guidelines for Point-of-Entry Staff (Non-Substance-Abuse Treatment Providers)*** | |
| **Goals** | **Guidelines** |
| Attitudes | * To be nonjudgmental, supportive, and respectful * To be culturally responsive and appropriate |
| Skills | * To actively listen and express concern * To treat all women with respect and dignity * To engage women in nonthreatening discussions * To routinely screen for alcohol and substance use and abuse (e.g., complete a behavioral checklist, identify behavioral signs) * To recognize signs of intoxication and symptoms of mental disorders * To facilitate appropriate referrals for women who abuse substances |
| Knowledge | * To understand women's lives in sociocultural, psychological, economic, and political contexts * To learn about the etiology, symptoms, consequences, and course of substance use disorders among women * To know the available treatment and support resources for women who abuse substances and how to make a referral * To continue to learn drug language and culture * To understand the diverse experiences of women from different cultural groups, sexual orientations, and gender identities |

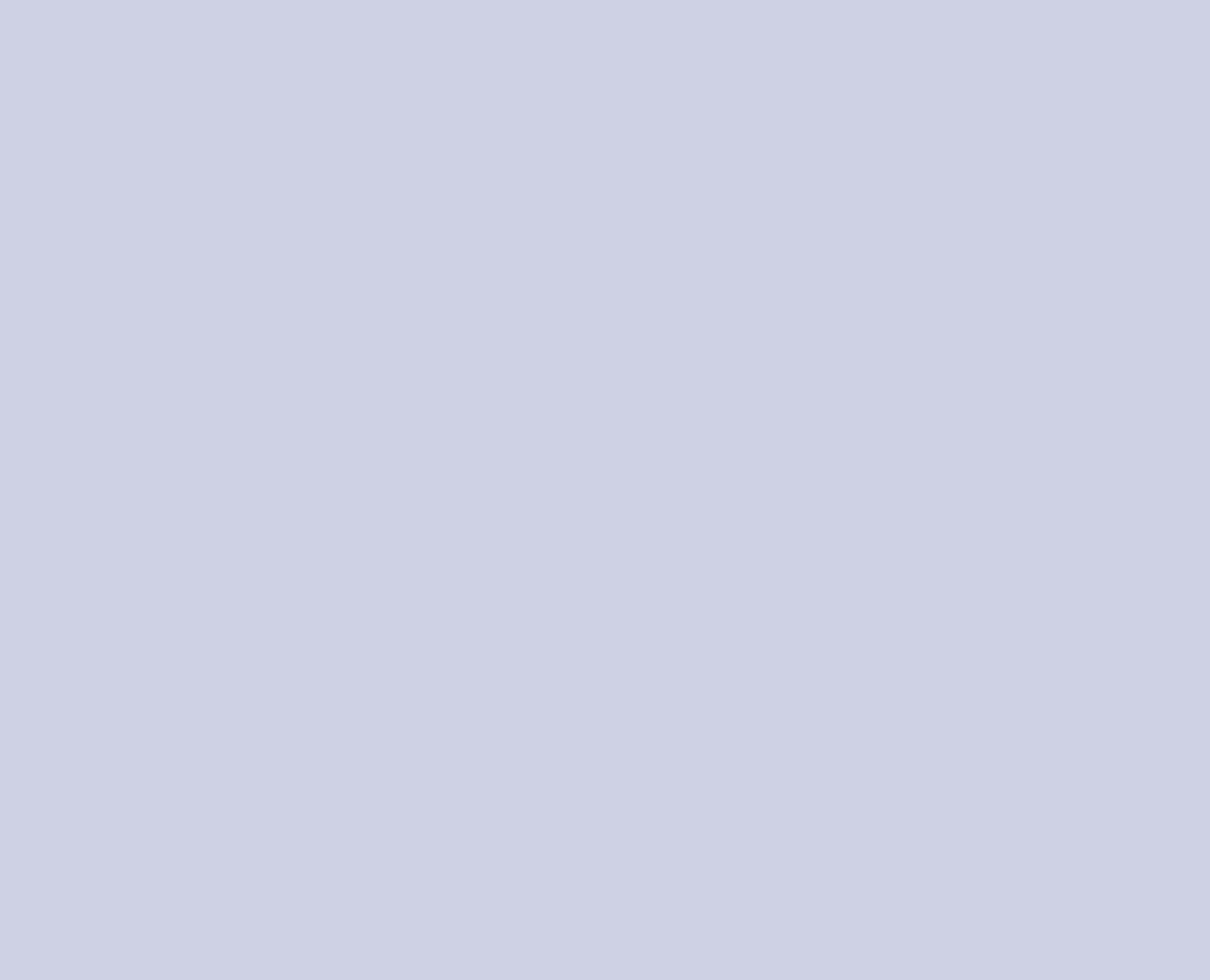
experience. Some clients need to feel empowered to assume new roles, make decisions and a new life, and remain substance free. Treatment staff can help clients find acceptance, understand their conflicts, and reach comfortable roles.

Figure 8-4 defines the attitudes, skills, and knowledge that training should instill in an audience of substance abuse treatment counselors.

Supervision

The consensus panel recommends that staff supervision be built into an agency's procedures on two levels: administrative supervision (timesheets, policies, etc.) and clinical supervision. Clinical supervision provides a method to address countertransference issues or other problems when a staff member's

values, attitudes, and/or expectations might interfere with the therapeutic process.

Clinical supervisors can help counselors foster therapeutic alliances and help providers

learn to use the therapeutic relationship to model and foster mutuality, respect, and connection for women (Finkelstein 1996; Finkelstein et al. 1997). Literature from cross­ cultural psychology and social work shows that therapeutic relationships with those who have substance use problems are stronger and more effective if the counselor understands the client's historical, cultural, and economic background (Pedersen et al. 1989; Sue and Sue 2003). Research in psychology shows that counselors' gender and ethnicity can affect the

diagnoses they assign (Loring and Powell 1988). This speaks to the need for ongoing clinical

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| ***Figure 8-4 Goals and Training Guidelines for Substance Abuse Treatment***  ***Counselors*** | |
| **Goals** | **Guidelines** |
| Attitudes | * To maintain a nonjudgmental, supportive, and respectful manner * To understand the diverse experience of women from different cultural groups, abilities, sexual orientations, and gender identities (e.g., be aware of attitudes toward race, sex, and disability) * To be committed to women's issues * To uphold a sense of hope * To demonstrate unconditional acceptance of and positive regard for the client |
| Skills | * To engage women with empathy, warmth, and sincerity * To develop a treatment alliance with female clients that is mutual and collaborative, individualized, and continually negotiated * To have clear professional boundaries (neither distant nor abandoning) and maintain confidentiality * To remain consistent in caring and availability and possess the ability to set limits in a calm and supportive manner * To conduct assessments that are thorough and trauma informed * To develop individually focused and outcome-oriented treatment plans * To work with multidisciplinary teams * To perform crisis intervention * To apply trauma coping skills * To tolerate one's own distress in hearing trauma information * To deliver client-led treatment (e.g., help the client learn how to manage her distress without shutting down or becoming overwhelmed-a central focus of treatment) * To maintain and ensure self-care * To support clients' cultural and racial identities and sexual orientations * To ask for and participate in supervision, in part to explore personal biases in ongoing processes, and to be invested in ongoing training * To be a visible advocate for women who use/abuse substances for stigma reduction and for treatment (within treatment teams, the community, and the system) * To be an appropriate role model for women, including on the topic of parenting * To develop professional, respectful, mutually supportive, and collaborative relationships with coworkers |

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supervision of counselors and to the need for training individuals to be effective supervisors (Cramer 2002). Supervisors also can support staff members who are in recovery and working as volunteers or mentors.

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| ***Figure 8-4 Goals and Training Guidelines for Substance Abuse Treatment***  ***Counselors (continued)*** | |
| Knowledge | * To be culturally informed and knowledgeable * To be trauma informed, including awareness of the prevalence and impact of trauma on women's lives * To understand the psychological growth and development of women * To recognize the centrality of relationships for women, particularly parenting and social roles and the socialization process * To be knowledgeable about the physiology of women as it relates to substance use and abuse * To understand the etiology of substance abuse in women * To be familiar with the co-occurring disorders that commonly occur in women * To understand the context of abuse and patterns of use for women * To identify the consequences of substance abuse (e.g., legal, general health, infectious diseases, family and relationships, psychological) * To understand the treatment and recovery experience of women * To identify family dynamics (e.g., family of origin, parenting, child development) * To be familiar with a woman's process of recovery * To be knowledgeable about relapse prevention for women; relapse triggers such as family reunification; recovery resources; maintaining a safe place for the client; and loss, grief, and mourning * To understand issues related to sexuality, sexual orientation, and gender identity for women and their relationship to substance abuse * To know confidentiality rules and guidelines |

*Clinical supervision for trauma*

The management of the powerful effect associated with trauma presents challenges for counselors. As a result of their intense daily contact with trauma survivors, counselors are vulnerable to many symptoms and conditions including:

*Vicarious traumatization.* The experiences of trauma frequently are overwhelming for clients. As counselors listen to the life experiences of their clients, they too are at risk of becoming overwhelmed. Counselors can develop symptoms of depression, such as sleep disturbance, loss of appetite, or loss of pleasure in usually enjoyable

activities. Programs can take various steps to lessen the effect of vicarious traumatization:

* *Training.* Staff training on trauma issues (including vicarious traumatization) and on the connections between trauma, substance abuse, and mental illness, help staff address trauma experiences.
* *Supervision.* Regular clinical supervision helps counselors unburden themselves. The sooner a counselor's distress is addressed, the easier it is to manage. Understanding the counselor's emotional vulnerabilities when she works with women who were traumatized is essential to providing effective treatment and allowing staff to work well, safely, and consistently.
* *Debriefing.* Managers and supervisors need to ensure that counselors debrief after hearing painful and intense histories from their clients and to watch for signs of counselors becoming overwhelmed.
  + *Self-care.* Agency support should include awareness and education about signs of burnout, breaks from work, vacations, and varied schedules (i.e., with periods ofless exposure to trauma histories).
  + *Employee services.* Through peer support groups, an agency can acknowledge that vicarious traumatization is taking place and that its employees' ability to do their jobs well is important.
  + *Staff appreciation.* Program managers and supervisors should be aware that staff

members perform an important function as role models; they need to let staff members know they are valued. Counselors need to be examples of assertive, appropriate, high­ functioning adults.

Supervision for counselors can he understood in a rock-climbing metaphor. The client has

survived a terrible experience; it is as if she were on a high and windy ledge, still alive, but unable to find her way hack to safety. To help her, the counselor must go out on the ledge; calling to

her from safe ground will not do. To manage the task, the counselor must he tied to a supervisor, much as a rock climber is tied to another climber, to keep from falling (Cramer 2002).

###### Strategies for Organizational Change

A program seeking to become woman-centered cannot limit the transformation process to simply adopting superficial elements of the treatment culture (Markoff et al. 2005), such as creating a female-only program without changing program structure, integrating services, or building collaborative relationships across community agencies. Rather, it must

use numerous strategies and endorse a change model to ensure organizational change is deep, pervasive, and across systems. The consensus panel recommends the following:

* + *Training and education.* Staff members need help in identifying their biases and assumptions. Such training does not have to be intensive or expensive to he effective. For example, agencies can trade speakers.
* *Policies and procedures.* It is critical that programs have clear policies and procedures, and that women are informed of these policies and procedures at the beginning

of their treatment. Programs must be consistent in how they implement policies and procedures. This is important from both a program management perspective and a clinical treatment perspective. Having clear, reasonable standards that are implemented uniformly creates a safe and predictable environment for clients.

Drug and alcohol testing and searches for contraband must he done respectfully, letting the client know it is part of treatment and seeking her cooperation.

It is necessary to spend time building a relationship with the client and to give her an opportunity to admit to a relapse or to remove items that are not permitted in a residential community.

Staff must reinforce policies and rules uniformly and without preferential treatment. Fairness and justice are critical for women in treatment, and they must be modeled by the staff.

Rules and punitive restrictions must he germane to treatment. For example, some programs do not allow women to **talk** to their children for the first 30 days of treatment. Such a blanket rule is inappropriate for children and shows disrespect for the importance of the

mother-child relationship. Arbitrary rules are disempowering for women and not

part of a collaborative relationship. The treatment milieu is a model for parent­ child relationships, in which the use of arbitrary rules is discouraged. Following rules and procedures should not result in acts that retraumatize women. For example, it could be frightening for some

women to have counselors check rooms at night while the women are sleeping.

* *Top-down support for change.* Advocacy

for the program's philosophy of treatment is essential. It must he top down and explicit.

* *Hiring, retention, and promotion.* Programs

must reflect women's needs, possibly

including onsite daycare for staff, sick- child care, support (both financial and technical) for staff to become certified as addiction counselors, onsite training, and a good health benefits package. The programs should consider ways in which male staff members can contribute to woman-centered

programming. Staff members are more likely to support staffing policies and procedures when they are involved in their development.

* + *Consumer input.* The development of consumer advisory boards allows clients to share their input and lets them know their opinions are valued and respected.
  + *Relationships.* Positive relationships are of immeasurable value to women. How staff members relate to one another is part of the treatment milieu. Administrators need to model respectful relationships with clients and staff and incorporate support services for staff issues, such as mediation for

staff conflicts and peer support groups for handling job stress.

* + *The environment is a message.* Women recover best in a homelike atmosphere that is warm and welcoming for them and their children. The program environment needs to reflect the diverse cultures of the staff and clients; all groups can participate in designing, arranging, and furnishing the facility.
  + *Adopt a change model.* Administrators and supervisors need to develop a change plan to maintain a steadfast course in adopting new policies and procedures and in integrating services. Anticipation of roadblocks, methods for creating buy-in with staff, and strategies for building interagency relationships are a few issues that need consideration. Relevant resources to help support and guide change include the Relational Systems Change Model (Markoff et al. 2005a) and *The Change*

*Book: A Blueprint of Technology Transfer*

(Addiction Technology Transfer Center [ATTC] 2004).

* + *Collaborative relationships.* Establishing a collaborative relationship **with** the client provides the woman with an experience

of mutuality and shared power in a relationship, which in itself is part of healing.

At all times, staff members should work respectfully and in partnership with the client, and should:

Set a positive tone for the treatment relationship. Counselors get a good start by showing respect for the clients'

personal needs and comfort. For example, one treatment agency keeps a book that highlights the stories of women who have successfully completed treatment. Another offers clients food and drink. During a long client-assessment session, a counselor can offer a client a break instead of waiting for the client to ask for one. If possible, during the break the counselor should interact with the client so that

she does not feel alone. However, if she requests it, the client should have private time.

Treat substance abuse as a health issue, not a moral one. A client who feels judged is more likely to leave treatment. Let clients know how they can be involved in their treatment, explain the process to them, explain the roles of the treatment staff members, and explain when clients will make decisions with staff about their treatment (i.e., during treatment planning, reassessments, discharge).

Allow time to hear the client's stories. Too often, a client's low self-esteem is made even lower by cues that there is not enough time to listen to her.

Do what is necessary to ensure that the client understands the assessment and treatment processes. For a client with cognitive impairment, this can involve breaking down the process into short sessions, repeating or explaining

questions, proceeding more slowly, using less abstract language, or presenting information in an alternative format.

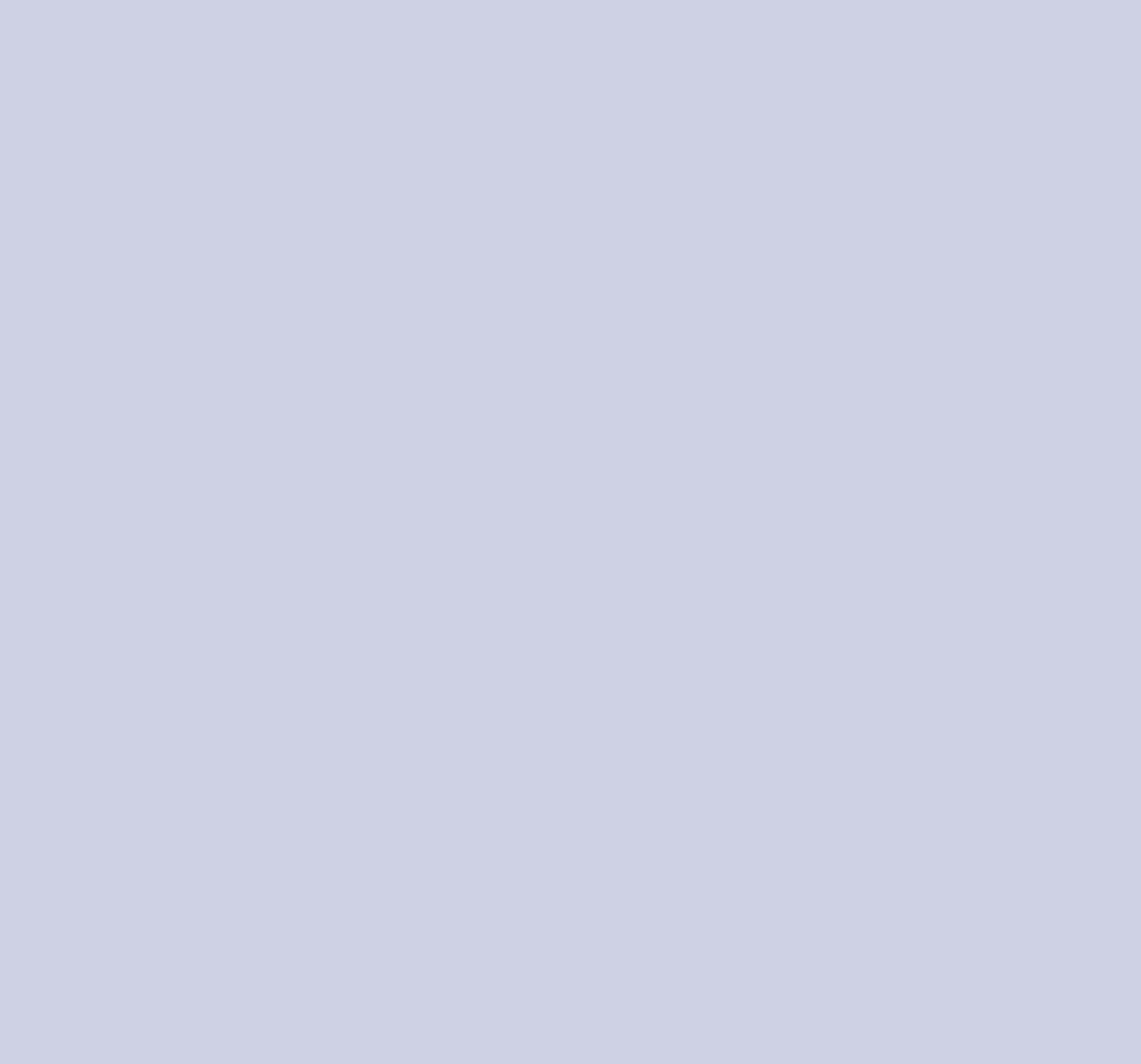
Seek feedback from the client on how her treatment plan is working. Inquire where she is in relation to her goals for

treatment, her life, and her feelings about her progress. Implement formal strategies to obtain client feedback on a regular basis instead of gathering this data at the termination of treatment.

When addressing noncompliance with clients, involve them in identifying the problem and its solution. Use policies that are educational rather than punitive. For example, encourage clients to examine the behaviors they need to change, how staff can help them in this process, an agreeable timeframe for doing so, and so on.

*State substance abuse treatment* standards for women

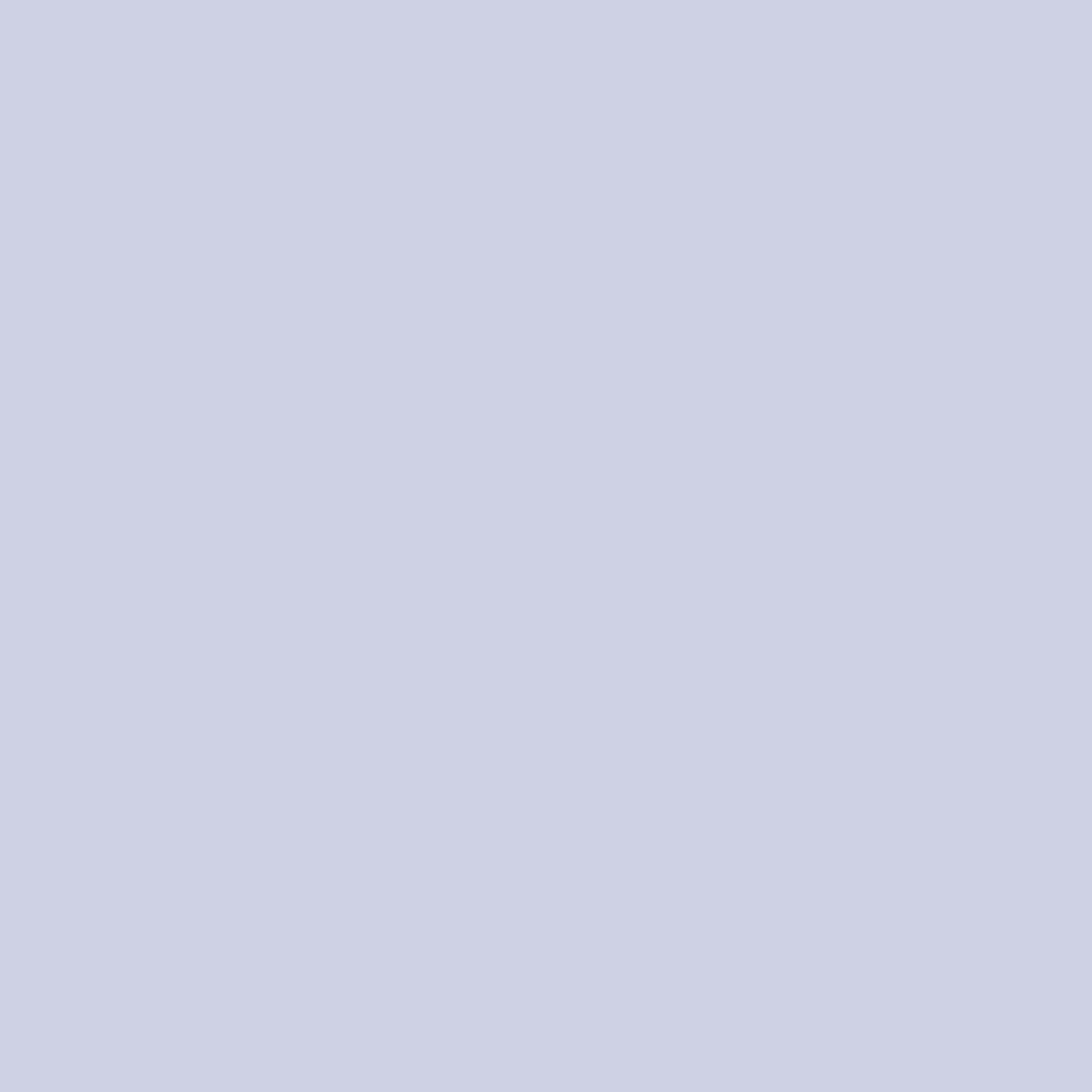
To provide general guidance in establishing and

providing services for women, administrators

and clinical staff benefit from reviewing available State standards or protocols for women, pregnant women, and women and children programs for substance abuse treatment (for review, see CSAT 2007). Figure 8-5 provides examples of State standards of gender-specific treatment across the continuum of care.

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| ***Figure 8-5 State Standard Examples of Gender-Specific Treatment*** | |
| **Gender-Specific Won1en Services** | **State Standard Examples** |
| Treatment Approach | * A relational or cultural approach that focuses on the relevance and centrality of relationships for women must be a vital ingredient in treatment * Selected treatment approaches shall be grounded in evidence-based or best practices for women |
| Screening/ Assessment | * Screening and assessments shall involve the use of tools, including the Addiction Severity Index and Stages of Change/Readiness Assessment * Assessments shall evaluate barriers to treatment and related services * Assessment and documentation of a client's need for prenatal care shall be included in the assessment process * History and assessment of interpersonal violence shall be evaluated * Sensitivity to retraumatization must be taken into consideration in the assessment process * Assessment shall be a collaborative process across agencies |
| Treatment Planning | * Planning shall include participation of significant others and other agencies; i.e., child welfare, correction, and other social service agencies |
| Treatment Programs | * Emotional and physical safety of women shall take precedence over all other considerations in the delivery of services * Women-only therapeutic environments shall be made available * Treatment shall include psychoeducation on the impact of gender on development and functioning in society * Treatment must be strength-based |

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| ***Figure 8-5 State Standard Examples of Gender-Specific Treatment (continued)*** | |
| Treatment Services | * Services must provide prenatal and childcare services * Treatment shall include smoking cessation strategies and programs * Services shall include child safety, parenting, and nutrition services * Wrap-around and integrated interagency and intra-agency services must be an integral part of treatment delivery services |
| Trauma-Informed and Integrated Trauma Services | * Treatment considerations shall incorporate an understanding of the way symptoms of trauma affect treatment, progress in treatment, and the relationship among counselor, program, and client |
| Co-Occurring Disorders | * Treatment must include symptom management strategies * Services for mental health and substance abuse treatment shall be integrated and coordinated |
| Staffing | * The program must provide gender-specific staff * Treatment services shall involve a majority of women as staff members |
| Support Systems | * The program shall make use of peer supports * Referrals shall be made to female-dominated support groups where available |
| Staff Training | * Formal staff training in women's treatment needs must include family counseling, trauma-informed services, prenatal education, etc. |
| Program Evaluation | * Program must measure short- and long-term impact of interventions, including educational attainment, employment, housing, parenting and reunification with children, and physical and mental health |
| *Source:* Adapted from Connecticut Treatment Guidelines 2007; Colorado Alcohol and Drug Almse Division Substance Use Disorder Treatment Rules 2006; Oklahoma Department of Mental Health and Substance Abuse Services Standards and Criteria for Alcohol and Drug Treatment Programs 2008; and Oregon Department of Human Services Standards for Outpatient and Residential Alcohol and Drug Treatment Programs 2008. | |



***Guidance to States: Treatment Standards for Women with Substance***

***Use Disorders***

This document serves as a comprehensive guide to assist States in creating their own treatment standards for women with substance use disorders. It provides a summary of existing State standards and incorporates other relevant resources pertinent to women's treatment needs across multiple service systems. Specific concerns for special populations are addressed, such as pregnant women, women with children, and women involved in the criminal justice system (The National Association of State Alcohol and Drug Abuse Directors 2008; see http://www.nasadad. org/resource.php?base\_id=l482).

# Appendix A: Bibliography

Ahs, R., Verhelst, J., Maeyaert, J., Van Buyten, J.P., Opsomer, F., Adriaensen, H., Verlooy, J., Van Havenbergh, T., Smet, M., and Van Acker, K. Endocrine consequences of long-term intrathecal adminis­ tration of opioids. *Journal of Clinical Endocrinology and Metabolism* 85(6):2215-2222, 2000.

Ackard, D.M., and Neumark-Sztainer, D. Multiple sexual victimizations among adolescent boys and girls: Prevalence and associations with eating behaviors and psychological health. *Journal of Child Sexual Abuse* 12(1):17-37, 2003.

Acker, C. Neuropsychological deficits in alcoholics: the relative contri­ butions of gender and drinking history. *British Journal of Addiction* 81(3):395-403, 1986.

Adams, H., and Phillips, L. Experiences of two-spirit lesbian and gay Native Americans: An argument for standpoint theory in identity research. *Identity* 6(3):273-291, 2006.

Addiction Technology Transfer Center. *The Change Book: A Blueprint for Technology Transfer.* 2nd ed. Kansas City, MO: Addiction Tech­ nology Transfer Center, 2004.

Adler, N.E., and Coriell, M. Socioeconomic status and women's health. In: Gallant, S.J., Keita, G.P., and Royak-Schaler, R., eds. *Health Care for Women: Psychological, Social, and Behavioral Influences.* Washington, DC: American Psychological Association Press, 1997. pp. 11-23.

Agrawal, A., Gardner, C.O., Prescott, C.A., and Kendler, K.S. The dif­ ferential impact of risk factors on **illicit** drug involvement in females. *Social Psychiatry and Psychiatric Epidemiology* 40(6):454-466, 2005.

Aguirre-Molina, M., Molina, C.W., and Zambrana, R.E. *Health Issues in the Latino Community.* San Francisco: Jossey-Bass, 2001.

Alati, R., Al, M.A., Williams, G.M., O'Callaghan, M., Najman, J.M., and Bor,

W. In utero alcohol exposure and prediction of alcohol disorders in early adulthood: a birth cohort study. *Archives of General Psy­ chiatry* 63(9):1009-1016, 2006.

Alegria, **M.,** Canino, G., Rios, **R.,** Vera, **M.,** Calderon, J., Rusch, D., and Ortega, A.N. Mental health care for Latinos: Inequalities in use of specialty mental health services among Latinos, African Americans, and Non-Latino Whites. *Psychiatric Services* 53(12):1547-1555, 2002.

Alexander, M.J. Women with co-occurring ad­ dictive and mental disorders: An emerging profile of vulnerability. *American Journal of Orthopsychiatry* 66(1):61-70, 1996.

Allen, D.N., Frantom, L.V., Forrest, T.J., and Strauss, G.P. Neuropsychology of substance use disorders. In: Snyder, P.J., Nussbaum, P.D., and Robins, D.L., eds. *Clinical Neu­ ropsychology: A Pocket Handbook for Assessment, 2nd ed.* 1-59147-283-0 (paper­ back). American Psychological Association: Washington, 2006. pp. 649-673.

Allen, **J.P.** The interrelationship of alcoholism assessment and treatment. *Alcohol Health and Research World* 15:178-185, 1991.

Allen, K. Barriers to treatment for addicted African-American women. *Journal of the National Medical Association* 87(10):751- 756, 1995.

Altarriba, **J.,** and Bauer, L.M. Counseling the Hispanic client: Cuban Americans, Mexican Americans, and Puerto Ricans. *Journal of Counseling* & *Development* 76(4):389-396, 1998.

Alvarez, L.R., and Ruiz, P. Substance abuse in the Mexican American population. In: Straussner, S.L.A., ed. *Ethnocultural Fac­ tors in Substance Abuse Treatment.* New York: Guilford Press, 2001. pp. 111-136.

Amaro, H., and Aguiar, M. Programa Mama/ Mom's Project: A community-based outreach model for addicted women. In: Szapocznik, J., Orlandi, M.A., and Epstein, L.G., eds. *A Hispanic/Latino Family Approach to Sub­ stance Abuse Prevention.* CSAP Cultural Competence Series 2. HHS Publication No. (SMA) 95-3034. Rockville, **MD:** Center for Substance Abuse Prevention, 1995. pp.

125-153.

Amaro, H., and de la Torre, A. Public health needs and scientific opportunities in research on Latinas. *American Journal of Public Health* 92(4):525-529, 2002.

Amaro, H., and Hardy-Fanta, C. Gender rela­ tions in addiction and recovery. *Journal of Psychoactive Drugs* 27(4):325-337, 1995.

Amaro, **H.,** Chernoff, M., Brown, V., Arevalo, S., and Gatz, **M.** Does integrated trauma­ informed substance abuse treatment increase treatment retention? *Journal of Commzmity Psychology* 35(7):845-862, 2008.

Amaro, **H.,** Larson, **M.J.,** Gampel, **J.,** Richard­ son, E., Savage, A., and Wagler, **D.** Racial/ ethnic differences in social vulnerability among women with co-occurring mental health and substance abuse disorders: Im­ plications for treatment services. *Journal of Community Psychology* 33(4):495-511, 2005.

Amaro, H., Larson, M.J., Zhang, A., Acevedo, A., Dai, J., and Matsumoto, A. Effects of trauma intervention on HIV sexual risk be­ haviors among women with co-occurring dis­ orders in substance abuse treatment. *Jour­ nal of Community Psychology* 35(7):895-908, 2007.

Amaro, **H.,** Nieves, **R.,** Johannes, S.W., and Labault Cabeza, **N.M.** Substance abuse treatment: Critical issues and challenges in the treatment of Latina women. *Hispanic Journal of Behavioral Sciences* 21(3):266- 282, 1999.

Amaro, H., Whitaker, R., Coffman, G., and Heeren, T. Acculturation and marijuana and cocaine use: Findings from HHANES

1982-84. *American Journal of Public Health*

80(Supplement):54-60, 1990.

American Association of Community Psychia­ trists. LOCUS - Level of Care Utilization System, Psychiatric and Addiction Services. Adult Version, 2000.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders.* 4th ed. Washington, DC: American Psychiat­ ric Association, 1994.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disor­ ders.* 4th Text Revision ed. Washington, DC: American Psychiatric Association, *2000a.*

American Psychiatric Association. *Position Statement on Therapies Focused on Memo­ ries of Childhood Physical and Sexual Abuse.* Washington, DC: American Psychiat­ ric Association, *2000b.*

American Psychological Association - Presiden­ tial Task Force on Violence and the Fam- ily. *Violence and the Family: Report of the American Psychological Association Presi­*

*dential Task Force on Violence and the Fam­ ily.* Washington, DC: American Psychological Association, 1996.

American Society of Addiction Medicine. *Pa­ tient Placement Criteria for the Treatment of Substance-Related Disorders: ASAM PPC-2.* 2d ed. Chevy Chase, MD: American Society of Addiction Medicine, 1996.

American Society of Addiction Medicine. *Pa­ tient Placement Criteria for the Treatment of Substance-Related Disorders: ASAM*

*PPC-2R.* 2d - Revised ed. Chevy Chase, MD: American Society of Addiction Medicine, 2001.

Ames, G., and Mora, **J.** Alcohol problem pre­ vention in Mexican American populations. In: Gilbert, **M.J.,** ed. *Alcohol Consumption Among Mexicans and Mexican Americans: A Binational Perspective.* Los Angeles: Univer­ sity of California, 1988. pp. 253-281.

Ammendola, A., Gemini, D., Iannaccone, S., Argenzio, F., Ciccone, G., Ammendola, E., Serio, L., Ugolini, G., and Bravaccio, F. Gender and peripheral neuropathy in chron­ ic alcoholism: Clinical-electroneurographic study. *Alcohol and Alcoholism* 35(4):368- 371, 2000.

Amodeo, M., and Jones, L.K. Viewing alcohol and other drug use cross culturally: A cul­ tural framework for clinical practice. *Fami­ lies in Society* 78(3):240-254, 1997.

Anda, R.F., Whitfield, C.L., Felitti, V.J., Chap­

man, D., Edwards, V.J., Dube, S.R., and Williamson, D.F. Adverse childhood expe­ riences, alcoholic parents, and later risk of alcoholism and depression. *Psychiatric Services* 53(8):1001-1009, 2002.

Andersen, A., Due, P., Holstein, B.E., and Iversen, L. Tracking drinking behaviour from age 15-19 years. *Addiction* 98(11):1505-

1511, 2003.

Andersen, M. Health needs of drug dependent clients: Focus on women. *Women and Health* 5(1):23-33, 1980.

Anderson, F., Paluzzi, P., Lee, J., Huggins, G., and Huggins, G. Illicit use of clonidine in opiate-abusing pregnant women. *Obstetrics and Gynecology* 90(5):790-794, 1997.

Anderson, S.C. Substance abuse and depen­ dency **in** gay men and lesbians. **In:** Peterson, **K.J.,** ed. *Health Care for Lesbians and Gay Men: Confronting Homophobia and Hetero­ sexism.* Binghamton, NY: Haworth Press, 1996. pp. 59-77.

Andrykowski, M.A., Cordova, M.J., Studts, J.L., and Miller, T.W. Posttraumatic stress disorder after treatment for breast cancer: Prevalence of diagnosis and use of the PTSD Checklist--Civilian Version (PCL--C) as a screening instrument. *Journal of Consult­ ing and Clinical Psychology* 66(3):586-590, 1998.

Antai-Otong, D. Women and alcoholism: Gen­ der-related medical complications: Treat­ ment considerations. *Journal of Addictions Nursing* 17(1):33-45, 2006.

Appel, P.W., Ellison, A.A., Jansky, H.K., and Oldak, R. Barriers to enrollment in drug abuse treatment and suggestions for reduc­ ing them: opinions of drug injecting street outreach clients and other system stakehold­ ers. *American Journal of Drug and Alcohol Abuse* 30(1):129-153, 2004.

Aquilino, W.S. Interview mode effects in sur­ veys of drug and alcohol use: A field experi­ ment. *Public Opinion Quarterly* 58(2):210- 240, 1994.

Arborelius, E., and Damstrom, T.K. Why is it so difficult for general practitioners to dis­ cuss alcohol with patients? *Family Practice* 12(4):419-422, 1995.

Archie, C. Methadone in the management of narcotic addiction in pregnancy. *Cur­*

*rent Opinion in Obstetrics and Gynecology*

10(6):435-440, 1998.

Arfken, C.L., Klein, C., di Menza, S., and Schuster, C.R. Gender differences in prob­ lem severity at assessment and treatment retention. *Journal of Substance Abuse Treat­ ment* 20(1):53-57, 2001.

Arnett, J.J. The developmental context of sub­ stance use in emerging adulthood. *Journal of Drug Issues* 35(2):235-254, 2005.

Ashley, O.S., Sverdlov, L., and Brady, T.M. Length of stay among female clients in substance abuse treatment. *Health Services Utilization by Individuals With Substance Abuse and Mental Disorders* Council, C. **L.** (HHS Publication No. SMA 04-3949, Ana­ lytic Series A-25) Rockville, **MD:** Substance Abuse and **Mental** Health Services Adminis­ tration, 2004.

Augustyn, M., Parker, S., Groves, B., and Zuckerman, B. Silent victims: Children who witness violence. *Contemporary Pediatrics* 12(8):35-37, 1995.

Ayala, J., and Coleman, H. Predictors of de­ pression among lesbian women. *Journal of Lesbian Studies* 4(3):71-86, 2000.

Babor, T.F., and Grant M. From clinical re­ search to secondary prevention: Interna­ tional collaboration in the development of the Alcohol Use Disorders Identification Test (AUDIT). *Alcoholism and Health Research World* 13:371-374, 1989.

Babor, T.F., McRee, B.G., Kassebaum, P.A., Grimaldi, P.L., Ahmed, K., and Bray, J. Screening, Brief Intervention, and Refer­ ral to Treatment (SBIRT): Toward a public health approach to the management of sub­ stance abuse. *Substance Abuse* 28(3):7-30, 2007.

Baca, C.T., Alverson, D.C., Manuel, J.K., and Blackwell, G.L. Telecounseling in rural areas for alcohol problems. *Alcoholism Treatment Quarterly* 25(4):31-45, 2007.

Bachu, A., and O'Connell, M. Fertility of An1er­ ican Women: June 2000. *Current Population Reports.P20-543RVWashington,* DC: U.S. Census Bureau, 2001.

Bagnardi, V., Blangiardo, M., La Vecchia, C., and Corrao, G. Alcohol consumption and the risk of cancer: A meta-analysis. *Alcohol Research and Health* 25(4):263-270, 2001.

Balcazar, H., and Qian, Z. Immigrant families and sources of stress. In: McKenry, P.C., and Price, S.J., eds. *Families and Change: Coping with Stressful Events and Transi­ tions.* 2d ed. Thousand Oaks, CA: Sage Publications, 2000. pp. 359-377.

Balsam, K.F., Huang, B., Fieland, K.C., Simo­ ni, J.M., and Walters, K.L. Culture, trauma, and wellness: a comparison of heterosexual and lesbian, gay, bisexual, and two-spirit Na­ tive Americans. *Cultural Diversity* & *Ethnic Minority Psychology* 10(3):287-301, 2004.

Barnes, J.S., and Bennett, C.E. *The Asian Population: 2000. Census 2000* BriefWash­ ington, DC: U.S. Census Bureau, 2002.

Barnes-Josiah, D.L. Undoing racism in pub­ lic health: A blueprint for action in urban MCH. CityMatCH at the University of Ne­ braska Medical Center. Omaha, NE, 2004.

Baron, M. Addiction treatment for Mexican American families. In: Krestan, J.A., ed. *Bridges to Recovery: Addiction, Family Therapy, and Multicultural Treatment.* New York: The Free Press, 2000. pp. 219-252.

Barsky, A.J., Peekna, H.M., and Borns, J.F. Somatic symptom reporting in women and men. *Journal of General Internal Medicine* 16(4):266-275, 2001.

Bassuk, E.L., Melnick, S., and Browne, A. Responding to the needs of low-income and homeless women who are survivors of family violence. *Journal of the American Medical Womens Association* 53(2):57-64, 1998.

Bateman, D.A., and Chiriboga, C.A. Dose­ response effect of cocaine on newborn head circumference. *Pediatrics* 106(3):E33, 2000.

Battle, C.L., Zlotnick, C., Najavits, L.M., Gutierrez, M., and Winsor, C. Posttraumatic stress disorder and substance use disorder among incarcerated women. In: Ouimette, P., and Brown, P.J., eds. *Trauma and Sub­ stance Abuse: Causes, Consequences, and Treatment of Comorbid Disorders.* Washing­ ton, DC: American Psychological Associa­ tion, 2003. pp. 209-225.

Bauer, C.R., Langer, J.C., Shankaran, S.,

Bada, H.S., Lester, **B.,** Wright, L.L., Krause-Steinrauf, **H.,** Smeriglio, V.L., Finnegan, L.P., Maza, P.L., and Verter, J. Acute neonatal effects of cocaine exposure during pregnancy. *Archives of Pediatrics* & *Adolescent Medicine* 159(9):824-834, 2005.

Beatty, L.A. Substance abuse, disabilities, and black women: An issue worth exploring.

*Women* & *Therapy* 26(3-4):223-236, 2003.

Beauvais, F., Wayman, J.C., Jumper Thurman, P., Plested, B., and Helm, H. Inhalant abuse among American Indian, Mexican American, and non-Latino white adolescents. *Ameri­ can Journal of Drug and Alcohol Abuse* 28(1):171-187, 2002.

Beck, A.J. *Prisoners in 1999.* NCJ 183476 Washington, DC: Bureau of Justice Statis­ tics, 2000.

Beck, A.J., and Harrison, **P.M.** Prisoners **in** 2000. *Bureau of Justice Statistics Bulletin* Washington, DC: Bureau of Justice Statis­ tics, 2001.

Beck, A.J., Karberg, J.C., and Harrison, P.M. *Prison and Jail Inmates at Midyear 2001.* NCJ 191702 Washington, DC: Bureau of Justice Statistics, 2002.

Beck, A.T. *Beck Anxiety Inventory.* San An­ tonio, TX: The Psychological Corporation, 1993.

Beck, A.T., Steer, R.A., and Brown, G.K. *Beck Depression Inventory* - *II Manual.* San An­ tonio, TX: The Psychological Corporation, 1996a.

Beck, R.W., Jijon, C.R., and Edwards, J.B. The relationships among gender, perceived financial barriers to care, and health sta­ tus in a rural population. *Journal of Rural Health* 12(3):188-189, 1996b.

Becker, U., Deis, A., Sorensen, T.I., Gron­ baek, M., Borch-Johnsen, K., Muller, C.F., Schnohr, P., and Jensen, G. Prediction of risk of liver disease by alcohol intake, sex, and age: A prospective population study.

*Hepatology* 23(5):1025-1029, 1996.

Becker, **M.A.,** and Gatz, M. Introduction to the impact of co-occurring disorders and vio­ lence on women: Findings from the SAMHSA Women, Co-occurring Disorders and Vio­ lence Study. *Journal of Behavior Health Ser­ vices* & *Research* 32(2):111-112, 2005.

Beckman, L.J. Treatment needs of women with alcohol problems. *Alcohol Health and Re­ search World* 18(3):206-211, 1994.

Beckman, L.J., and Amaro, H. Personal and social difficulties faced by women and men entering alcoholism treatment. *Journal of Studies on Alcohol* 47(2):135-145, 1986.

Bell, B.P., Mast, E.E., Terrault, N., and Hutin,

Y.J. Prevention of hepatitis C in women. *Emerging Infectious Diseases* 10(11):2035- 2036, 2004.

Bell, E.C., Baker, G.B., Poag, C., Bellavance, F., Khudabux, J., and Le Melledo, J.M. Re­ sponse to flumazenil in the late luteal phase and follicular phase of the menstrual cycle in healthy control females. *Psychopharmacol­ ogy (Berl)* 172(3):248-254, 2004.

Bell, G.L., and Lau, K. Perinatal and neonatal issues of substance abuse. *Pediatric Clinics of North America* 42(2):261-281, 1995.

Bell, P. *Chemical Dependency and the African­ American: Counseling Strategies and Com­ munity Issues.* 2nd ed. Center City, MN: Hazelden, 2002.

Benshoff, **J.J.,** Harrawood, L.K., and Koch,

D.S. Substance abuse and the elderly: Unique issues and concerns. *Journal of Re­ habilitation* 69(2): 2003.

Bergmark, K.H. Drinking in the Swedish gay and lesbian community. *Drug and Alcohol Dependence* 56(2):133-143, 1999.

Berkowitz, G., Peterson, S., Smith, E.M., Taylor, **T.,** and Brindis, C. Community and treatment program challenges for chemically dependent American Indian and Alaska Na­ tive women. *Contemporary Drug Problems* 25(2):347-371, 1998.

Bernstein, D.P. Childhood trauma and drug addiction: Assessment, diagnosis, and treat­ ment. *Alcoholism Treatment Quarterly* 18(3):19-30, 2000.

Besharov, D.J., and Hanson, K.W. *When Drug Addicts Have Children: Reorienting Child Welfares Response.* Washington, DC: Child Welfare League of America, 1994.

Beutler, L.E., Machado, P.P., and Neufeldt,

S.A. Therapist variables. In: Bergin, A.E., and Garfield, S.L., eds. *Handbook of Psy­ chotherapy and Behavior Change.* 4th ed. Oxford: John Wiley and Sons, 1994. pp. 229-269.

Bickelhaupt, E.E. Alcoholism and drug abuse in gay and lesbian persons: A review of inci­ dence studies. *Journal of Gay and Lesbian Social Services* 2(1):5-14, 1995.

Black, S.A., and Markides, K.S. Acculturation and alcohol consumption in Puerto Rican, Cuban-American, and Mexican-American women in the United States. *American Jour­ nal of Public Health* 83(6):890-893, 1993.

Blanchard, E.B., Jones-Alexander, J., Buck­ ley, T.C., and Forneris, C.A. Psychometric properties of the PTSD Checklist (PCL). *Be­ haviour Research* & *Therapy* 34(8):669-673, 1996.

Block, R.I., Farinpour, R., and Schlechte, J.A. Effects of chronic marijuana use on testos­ terone, luteinizing hormone, follicle stimulat­ ing hormone, prolactin and cortisol in men and women. *Drug and Alcohol Dependence* 28(2):121-128, 1991.

Bloom, B., Owen, B., and Covington, S. *Gender-Responsive Strategies: Research, Practice, and Guiding Principles for Women Offenders.* Washington, DC: National Insti­ tute of Corrections, 2003.

Blow, F.C., and Barry, K.L. Use and misuse of alcohol among older women. *Alcohol Re­ search and Health* 26(4):308-315, 2002.

Blum, L.N., Nielsen, N.H., and Riggs, J.A. Alcoholism and alcohol abuse among women: Report of the Council on Scientific Affairs.

American Medical Association. *Journal of Womens Health* 7(7):861-871, 1998.

Blume, S. Sexuality and stigma. *Alcohol Health and Research World* 15(2):139-146, 1991.

Blume, S.B. Women and alcohol: Issues in social policy. In: Wilsnack, R.W., and Wilsnack,

S.C., eds. *Gender And Alcohol: Individual And Social Perspectives.* New Brunswick, **NJ:** Rutgers Center of Alcohol Studies, 1997. pp. 462-489.

Blumenthal, S.J. Women and substance abuse: A new national focus. In: Wetherington, C.L., and Roman, A.B., eds. *Drug Addiction Research and the Health of Women.* NIH Publication No. 98-4290. Rockville, MD: National Institute on Drug Abuse, 1998. pp. 13-32.

Bobo, J .K., Schilling, R.F., Gilchrist, L.D., and Schinke, S.P. The double triumph: Sustained sobriety and successful cigarette smoking cessation. *Journal of Substance Abuse Treat­ ment* 3(1):21-25, 1986.

Bolnick, **J.M.,** and Rayburn, W.F. Substance use disorders in women: special consider­ ations during pregnancy. *Obstetrics and Gy­ necology Clinics of North America* 30(3):545- 58, vii, 2003.

Borrelli, **B.,** Papandonatos, G., Spring, **B.,** Hitsman, B., and Niaura, **R.** Experimenter­ defined quit dates for smoking cessation: adherence improves outcomes for women but not for men. *Addiction* 99(3):378-385, 2004.

Bottorff, J.L., Johnson, J.L., Irwin, L.G., and Ratner, P.A. Narratives of smoking relapse: The stories of postpartum women. *Research in Nursing and Health* 23(2):126-134, 2000.

Boyd, M.B., Mackey, M.C., Phillips, K.D., and Tavakoli, A. Alcohol and other drug disorders, comorbidity and violence in rural African American women. *Issues in Mental Health Nursing* 27(10):1017-1036, 2006.

Boyd, **M.R.** Substance abuse in rural women.

*Nursing Connections* 11(2):33-45, 1998.

Boyd, M.R. Vulnerability to alcohol and other drug disorders in rural women. *Archives of Psychiatric Nursing* 17(1):33-41, 2003.

Boyd, M.R., and Mackey, M.C. Alienation from self and others: The psychosocial problem of rural alcoholic women. *Archives of Psychiat­ ric Nursing* 14(3):134-141, *2000a.*

Boyd, **M.R.,** and Mackey, M.C. Running away to nowhere: Rural women's experiences of becoming alcohol dependent. *Archives of Psychiatric Nursing* 14(3):142-149, *2000b.*

Boyd-Franklin, N. *Black Families In Therapy: A Multisystems Approach.* New York: Guil­ ford Press, 1989.

Boyd-Franklin, N., and Lockwood, T.W. Spiri­ tuality and religion: Implications for psycho­ therapy with African American families. In: Walsh, F., ed. Spiritual Resources In Family Therapy (2nd ed.). 978-1-60623-022-0 (hard­ cover). Guilford Press: New York, 2009. pp. 141-155.

Bradley, K.A., Badrinath, S., Bush, K., Boyd­ Wickizer, J., and Anawalt, B. Medical risks for women who drink alcohol. *Journal of General Internal Medicine* 13(9):627-639, 1998a.

Bradley, K.A., Boyd-Wickizer, J., Powell, S.H., and Burman, M.L. Alcohol screening ques­ tionnaires in women: A critical review. *JAMA* 280(2):166-171, 1998b.

Bradley, K.A., Bush, K.R., McDonell, M.B., Malone, T., and Fihn, S.D. Screening for problem drinking: Comparison of CAGE and AUDIT. Ambulatory Care Quality Improve­ ment Project (ACQUIP). Alcohol Use Disor­ ders Identification Test. *Journal of General Internal Medicine* 13(6):379-388, 1998c.

Brady, K. *Anxiety and Substance Abuse.* 154th Annual Meeting of the American Psychiatric Association May 5 - 10, 2001, New Orleans, Louisiana, 2001a.

Brady, K.T. Comorbid posttraumatic stress dis­ order and substance use disorders. *Psychiat­ ric Annals* 31(5):313-319, 2001b.

Brady, K.T., and Randall, C.L. Gender differ­ ences **in** substance use disorders. *Psychiatric Clinics of North America* 22(2):241-252, 1999.

Brady, K.T., Dansky, B.S., Back, S.E., Foa, E.B., and Carroll, **K.M.** Exposure therapy in the treatment of PTSD among cocaine­ dependent individuals: Preliminary find­ ings. *Journal of Substance Abuse Treatment* 21(1):47-54, 2001.

Brady, K.T., Killeen, T.K., Brewerton, T., and Lucerini, S. Comorbidity of psychiatric

disorders and posttraumatic stress disorder. *Journal of Clinical Psychiatry* 6l(Suppl 7):22-32, 2000.

Brady, T.M., and Ashley, O.S. Women In Sub­ stance Abuse Treatment: Results from the Alcohol and Drug Services Study (ADSS). (HHS Publication No. SMA 04-3968, Ana­ lytic Series A-26). Rockville, **MD:** Substance Abuse and Mental Health Services Adminis­ tration, Office of Applied Studies, 2005.

Brecht, M.L., O'Brien, A., Mayrhauser, C.V., and Anglin, **M.D.** Methamphetamine use behaviors and gender differences. *Addictive Behaviors* 29(1):89-106, 2004.

Brems, C. Substance use, mental health, and health in Alaska: Emphasis on Alaska Native peoples. *Arctic Medical Research* 55(3):135- 147, 1996.

Brennan, P.L., Moos, R.H., and Kim, J.Y. Gender differences in the individual char­ acteristics and life contexts of late-middle­ aged and older problem drinkers. *Addiction* 88(6):781-790, 1993.

Breslau, N., Davis, G.C., Andreski, P., and Peterson, E. Traumatic events and posttrau­ matic stress disorder in an urban population of young adults. *Archives of General Psy­ chiatry* 48(3):216-222, 1991.

Breslau, N., Davis, G.C., Andreski, **P.,** Peter­ son, E.L., and Schultz, **L.R.** Sex differences in posttraumatic stress disorder. *Archives of General Psychiatry* 54(11):1044-1048, 1997.

Bride, B.E. Single-gender treatment of sub­ stance abuse: Effect on treatment reten­ tion and completion. *Social Work Research* 25(4):223-232, 2001.

Brindis, C.D., and Theidon, K.S. The role of case management in substance abuse treat­ ment services for women and their children. *Journal of Psychoactive Drugs* 29(1):79-88, 1997.

Brome, D.R., Ownes, M.D., Allen, K., and Vevaina, T. An examination of spirituality among African An1erican women in recovery from substance abuse. *Journal of Black Psy­ chology* 26(4):470-486, 2000.

Bronfenbrenner, U. Ecological systems theory.

*Annals of Child Development* 6:187-249, 1989.

Brook, **D.W.,** Brook, J.S., Richter, L., Masci, J.R., and Roberto, J. Needle sharing: a longitudinal study of female injection drug users. *American Journal of Drug and Alco­ hol Abuse* 26(2):263-281, 2000.

Brook, J., Whiteman, M., Balka, E., Win, P., and Gursen, M. Similar and different pre­ cursors to drug use and delinquency among African Americans and Puerto Ricans.

*Journal of Genetic Psychology* 159(1):13-29,

1998.

Brown, E., Frank, D., and Friedman, A. *Sup­ plementary Administration Manual for the Expanded Female Version of the Addiction Severity Index (ASI) Instrument The ASI-*

*F.* HHS Publication Number 96-8056. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, 1997.

Brown, E.R., Ponce, N., and Rice, T. *The State of Health Insurance in California: Recent Trends, Future Prospects.* Los Angeles: UCLA Center for Health Policy Research, 2001.

Brown, P.J., Recupero, P.R., and Stout, R. PTSD substance abuse comorbidity and treatment utilization. *Addictive Behaviors* 20(2):251-254, 1995.

Brown, P.J., Stout, R.L., and Mueller, T. Posttraumatic stress disorder and sub­ stance abuse relapse among women: A pilot study. *Psychology of Addictive Behaviors* 10(2):124-128, 1996.

Brown, S.P., Lipford-Sanders, J., and Shaw,

M. Kujichagulia: Uncovering the secrets of the heart: Group work with African Ameri­ can women on predominantly white cam­ puses. *Journal for Specialists in Group Work* 20(3):151-158, 1995a.

Brown, T.G., Kokin, M., Seraganian, P., and Shields, N. The role of spouses of substance abusers in treatment: Gender differences. *Journal of Psychoactive Drugs* 27(3):223- 229, 1995b.

Brown, V.B. *Changing And Improving Services For Women And Children: Strategies Used And Lessons Learned.* Los Angeles, CA: Pro­ totypes Systems Change Center, 2000.

Brown, V.B., Najavits, L.M., Cadiz, S., Finkel­ stein, N., Heckman, **J.P.,** and Rechberger,

E. Implementing an evidence-based practice: Seeking Safety Group. *Journal of Psychoac­ tive Drugs* 39(3):231-240, 2007.

Brownridge, D.A. Partner violence against women with disabilities: Prevalence, risk, and explanations. *Violence Against Women* 12(9):805-822, 2006.

Brudenell, I. Parenting an infant during alco­ hol recovery. *Journal of Pediatric Nursing* 15(2):82-88, 2000.

Bryant, J., and Treloar, C. The gendered context of initiation to injecting drug use: evidence for women as active initiates. *Drug And Alcohol Review* 26(3):287-293, 2007.

Buchsbaum, D.G., Buchanan, R.G., Lawton, M.J., Elswick, R.K., Jr., and Schnoll, S.H.

A program of screening and prompting improves short-term physician counseling of dependent and nondependent harmful drinkers. *Archives of Internal Medicine* 153(13):1573-1577, 1993.

Bulik, C., and Sullivan, P. Comorbidity of eat­ ing disorders and substance-related disor­ ders. **In:** Kranzler, **H.R.,** and Rounsaville, B., eds. *Dual Diagnosis and Treatment: Sub­ stance Abuse and Cormorbid Medical and Psychiatric Disorders.* New York: Marcel Dekker, 1998.pp. 365-392.

Bulik, C.M., Klump, K.L., Thornton, L.,

Kaplan, A.S., Devlin, B., Fichter, M.M.,

Halmi, K.A., Strober, M., Woodside, D.B., Crow, S., Mitchell, J.E., Rotondo, A., Mau­ ri, M., Cassano, G.B., Keel, P.K., Berrettini, W.H., and Kaye, **W.H.** Alcohol use disorder comorbidity in eating disorders: A **multi­** center study. *Journal of Clinical Psychiatry* 65(7):1000-1006, 2004.

Bureau of Justice Statistics. *Compendium of Federal Justice Statistics, 2004.* Washington, DC: U.S. Department of Justice, 2006.

Bureau of the Census (Current Population Survey, March 2002, Ethnic and Hispanic Statistics Branch, Population Division).

Table 15.1 Poverty status of families in 2001 by family type and by Hispanic origin and race of householder: March 2002 [http://www.](http://www/) census.gov/population/socdemo/hispanic/

ppl-165/tabl5-l.pdf [Accessed September 17, 2008].

Burkett, G., Gomez-Marin, 0., Yasin, S.Y., and Martinez, M. Prenatal care in cocaine­ exposed pregnancies. *Obstetrics and Gyne­ cology* 92(2):193-200, 1998.

Burkett, G., Yasin, S.Y., Palow, D., LaVoie, L., and Martinez, M. Patterns of cocaine bing­ ing: Effect on pregnancy. *American Journal of Obstetrics and Gynecology* 171(2):372- 379, 1994.

Burling, T.A., Burling, A.S., and Latini, D.

A controlled smoking cessation trial for substance-dependent inpatients. *Journal of Consulting* & *Clinical Psychology* 69(2):295- 304, 2001.

Burns, L., Mattick, R.P., Lim, K., and Wal­ lace, C. Methadone in pregnancy: treatment retention and neonatal outcomes. *Addiction* 102(2):264-270, 2007.

Burt, V.K., and Stein, K. Epidemiology of depression throughout the female life cycle. *Journal of Clinical Psychiatry* 63(Sup­ pl7):9-15, 2002.

Bushy, A. Mental health and substance abuse: Challenges in providing services to rural clients. In: Center for Substance Abuse Treatment, ed. *Bringing Excellence To Sub­ stance Abuse Services In Rural And Frontier America.* Technical Assistance Publication Series 20. Rockville, MD: Center for Sub­ stance Abuse Treatment, 1997. pp. 45-53.

Butler, A.C., Chapman, J.E., Forman, E.M., and Beck, A.T. The empirical status of cognitive-behavioral therapy: a review of meta-analyses. *Clinical Psychology Review* 26(1):17-31, 2006.

Caetano, R. Alcohol use among Hispanic groups in the United States. *American Journal of Drug and Alcohol Abuse* 14(3):293-308, 1988.

Caetano, R. Drinking patterns and alcohol problems in a national sample of U.S. His­ panics. In: Spiegler, D., Tate, D., Aitken, S., and Christian, C., eds. *Alcohol Use Among*

*U.S. Ethnic Minorities: Proceedings Of A Conference On The Epidemiology Of Alco­ hol Use And Abuse Among Ethnic Minority Groups, September 1985.* NIAAA Research Monograph No. 18. HHS Publication No. (ADM) 89-1435. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism, 1989. pp. 147-162.

Caetano, **R.** Drinking and alcohol-related prob­ lems among minority women. *Alcohol Health and Research World* 18(3):233-241, 1994.

Caetano, **R.,** Ramisetty-Mikler, S., Vaeth, P.A.C., and Harris, T.R. Acculturation stress, drinking, and intimate partner violence among Hispanic couples in the

U.S. *Joiirnal of Interpersonal Violence*

22(11):1431-1447, 2007.

Caetano, R., Ramisetty-Mikler, S., Wallisch, L.S., McGrath, C., and Spence, R.T. Ac­ culturation, drinking, and alcohol abuse and dependence among Hispanics in the

Texas-Mexico border. *Alcoholism: Clinical* &

*Experimental Research* 32(2):314-321, 2008.

Caldwell, T.M., Rodgers, B., Jorm, A.F., Chris­ tensen, H., Jacomb, P.A., Korten, A.E., and Lynskey, M.T. Patterns of association

between alcohol consumption and symptoms of depression and anxiety **in** young adults. *Addiction* 97(5):583-594, 2002.

Camp, **J.M.,** and Finkelstein, N. Parenting training for women in residential substance abuse treatment: Results of a demonstration project. *Journal of Substance Abuse Treat­ ment* 14(5):411-422, 1997.

Canino, G. Alcohol use and misuse among Hispanic women: Selected factors, processes, and studies. *International Journal of the Ad­ dictions* 29(9):1083-1100, 1994.

Canino, G., Vega, W.A., Sribney, W.M., War­ ner, L.A., and Alegria, M. Social Relation­ ships, social assimilation, and substance use disorders among adult Latinos in the U.S. *Journal of Drug Issues* 38(1):69-101, 2008.

Carlson, B.E., Matto, H., Smith, C.A., and Eversman, M. A pilot study of reunification following drug abuse treatment: Recover­ ing the mother role. *Journal of Drug Issues* 36(4):877-902, 2006.

Carmen, E.H. Inner city community mental health: The interplay of abuse and race in chronic mentally ill women. In: Willie, C.V., Rieker, P.P., Kramer, B.M., and Brown, B.S., eds. *Mental Health: Racism and Sex­ ism.* Pittsburgh, PA: University of Pitts­ burgh Press, 1995. pp. 217-236.

Carmichael, S.L., and Ahluwalia, I.B. Corre­ lates of postpartum smoking relapse: Results from the pregnancy risk assessment monitor­ ing system (PRAMS). *American Journal of Preventive Medicine* 19(3):193-196, 2000.

Carney, C.P., and Jones, L.E. The influence of type and severity of mental illness on receipt of screening mammography. *Journal of Gen­ eral Internal Medicine* 21(10):1097-1104, 2006.

Carr, A., and McNulty, **M.** Eating disorders. In: Carr, A., and McNulty, **M.,** eds. *The Handbook Of Adult Clinical Psychology: An Evidence-Based Practice Approach.* 978-1- 58391-854-8 (paperback); 978-1-58391-853-l

(hardcover). Routledge/Taylor & Francis Group: New York, 2006. pp. 724-765.

Carroll, J.F.X., and McGinley, J .J. A screening form for identifying mental health problems in alcohol/other drug dependent persons. *Al­ coholism Treatment Quarterly* 19(4):33-47, 2001.

Carter, R.E., Haynes, L.F., Back, S.E., Herrin,

A.E., Brady, K.T., Leimberger, J.D., Sonne,

S.C., Hubbard, R.L., and Liepman, M.R. Improving the transition from residential to outpatient addiction treatment: Gender dif­ ferences in response to supportive telephone calls. *American Journal of Drug and Alcohol Abuse* 34(1):47-59, 2008.

Case, P., Austin, S.B., Hunter, D.J., Man- son, J.E., Malspeis, S., Willett, W.C., and Spiegelman, D. Sexual orientation, health risk factors, and physical functioning in the

Nurses' Health Study II. *Journal of Womens Health (Larchmt.)* 13(9):1033-1047, 2004.

Catalano, S. Intimate partner violence in the United States. *Bureau of Justice Statistics* Washington, DC: U.S. Department of Jus­ tice, 2007.

Center for Substance Abuse Prevention. *Ma­ ternal Substance Use Assessment Methods Reference Manual: A Review Of Screening And Clinical Assessment Instruments For Examining Maternal Use Of Alcohol, Tobac­ co, And Other Drugs.* CSAP Special Report

13. HHS Publication No. (SMA)93-2059. Rockville, **MD:** Substance Almse and Mental Health Services Administration, 1993.

Center for Substance Abuse Prevention. *Sub­ stance Abuse Resource Guide: Lesbian, Gay, Bisexual, And Transgender Populations.*

Revised 2000 ed. Rockville, **MD:** Center for Substance Abuse Prevention, 2000.

Center for Substance Abuse Treatment. *Improv­ ing Treatment for Drug-Exposed Infants.*

Treatment Improvement Protocol (TIP) Se­ ries 5. HHS Publication No. (SMA) 95-3057. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1993a.

Center for Substance Abuse Treatment. *Preg­ nant, Substance-Using Women.* Treatment Improvement Protocol (TIP) Series 2. HHS Publication No. (SMA) 93-1998. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1993b.

Center for Substance Abuse Treatment. *Screen­ ing for Infectious Diseases Among Substance Abusers.* Treatment Improvement Protocol (TIP) Series 6. HHS Publication No. (SMA) 95-3060. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1993c.

Center for Substance Abuse Treatment. *Practi­ cal Approaches in the Treatment of Women Who Abuse Alcohol and Other Drugs.* HHS Publication No. (SMA) 94-3006. Washing­ ton, DC: U.S. Government Printing Office, 1994a.

Center for Substance Abuse Treatment. *Simple Screening Instruments for Outreach for Al­ cohol and Other Drug Abuse and Infectious Diseases.* Treatment Improvement Protocol (TIP) Series 11. HHS Publication No. (SMA) 94-2094. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994b.

Center for Substance Abuse Treatment. *Alcohol and Other Drug Screening of Hospitalized Trauma Patients.* Treatment Improvement Protocol (TIP) Series 16. HHS Publication No. (SMA) 95-3041. Rockville, MD: Sub­ stance Abuse and Mental Health Services Administration, 1995a.

Center for Substance Abuse Treatment. *Com­ bining Alcohol and Other Drug Treatment with Diversion for Juveniles in the Justice System.* Treatment Improvement Protocol **(TIP)** Series 21. HHS Publication No. (SMA) 95-3051. Rockville, **MD:** Substance Abuse and Mental Health Services Administration, 1995b.

Center for Substance Abuse Treatment. *Devel­ oping State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treat­ ment.* Treatment Improvement Protocol (TIP) Series 14. HHS Publication No. (SMA) 95-3031. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1995c.

Center for Substance Abuse Treatment. *The Role and Current Status of Patient Place­ ment Criteria in the Treatment of Substance Use Disorders.* Treatment Improvement Pro­ tocol (TIP) Series 13. HHS Publication No. (SMA) 95-3021. Rockville, **MD:** Substance Abuse and Mental Health Services Adminis­ tration, 1995d.

Center for Substance Abuse Treatment. *The Tuberculosis Epidemic: Legal and Ethical Issues for Alcohol and Other Drug Abuse Treatment Providers.* Treatment Improve­ ment Protocol (TIP) Series 18. HHS Publi­ cation No. (SMA) 95-3047. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1995e.

Center for Substance Abuse Treatment. *Treat­ ment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Process­ ing.* Treatment Improvement Protocol (TIP) Series 23. HHS Publication No. (SMA)

96-3113. Rockville, **MD:** Substance Abuse and Mental Health Services Administration, 1996.

Center for Substance Abuse Treatment. *A Guide to Substance Abuse Services for Primary Care Clinicians.* Treatment Improvement Protocol (TIP) Series 24. HHS Publication No. (SMA) 97-3139. Rockville, MD: Sub­ stance Abuse and Mental Health Services Administration, 1997*a.*

Center for Substance Abuse Treatment. *Sub­ stance Abuse Treatment and Domestic Violence.* Treatment Improvement Protocol (TIP) Series 25. HHS Publication No. (SMA) 97-3163. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1997b.

Center for Substance Abuse Treatment. *Supple­ mentary Administration Manual For The Expanded Female Version Of The Addiction Severity Index (ASI) Instrument.* HHS Pub­ lication No. (SMA) 96-8056. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1997c.

Center for Substance Abuse Treatment. *Com­ prehensive Case Management for Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 27. HHS Publication No. (SMA) 98-3222. Rockville, MD: Sub­ stance Abuse and Mental Health Services Administration, 1998a.

Center for Substance Abuse Treatment. *Conti­ nuity of Offender Treatment for Substance Use Disorders From Institution to Com­ munity.* Treatment Improvement Protocol (TIP) Series 30. HHS Publication No. (SMA) 98-3245. Rockville, **MD:** Substance Abuse and Mental Health Services Administration, 1998b.

Center for Substance Abuse Treatment. *Nal­ trexone and Alcoholism Treatment.* Treat­ ment Improvement Protocol (TIP) Series

28. HHS Publication No. (SMA) 98-3206. Rockville, **MD:** Substance Abuse and Mental Health Services Administration, 1998c.

Center for Substance Abuse Treatment. *Sub­ stance Abuse Among Older Adults.* Treat­ ment Improvement Protocol (TIP) Series

26. HHS Publication No. (SMA) 98-3179. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1993d.

Center for Substance Abuse Treatment. *Sub­ stance Use Disorder Treatment for People With Physical and Cognitive Disabilities.* Treatment Improvement Protocol (TIP) Series 29. HHS Publication No. (SMA)

98-3249. Rockville, **MD:** Substance Abuse and Mental Health Services Administration, 1998e.

Center for Substance Abuse Treatment. *Brief Interventions and Brief Therapies for Sub­ stance Abuse.* Treatment Improvement Pro­ tocol (TIP) Series 34. HHS Publication No. (SMA) 99-3353. Rockville, **MD:** Substance Abuse and Mental Health Services Adminis­ tration, 1999a.

Center for Substance Abuse Treatment. *En­ hancing Motivation for Change in Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 35. HHS Publication

No. (SMA) 99-3354. Rockville, MD: Sub­ stance Abuse and Mental Health Services Administration, 1999b.

Center for Substance Abuse Treatment. *Screen­ ing and Assessing Adolescents for Substance Use Disorders.* Treatment Improvement Pro­ tocol (TIP) Series 31. HHS Publication No. (SMA) 99-3282. Rockville, **MD:** Substance Abuse and Mental Health Services Adminis­ tration, 1999c.

Center for Substance Abuse Treatment. *Treat­ ment of Adolescents With Substance Use Disorders.* Treatment Improvement Protocol (TIP) Series 32. HHS Publication No. (SMA) 99-3283. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999d.

Center for Substance Abuse Treatment. *Treat­ ment for Stimulant Use Disorders.* Treatment Improvement Protocol (TIP) Series 33. HHS Publication No. (SMA) 99-3296. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999e.

Center for Substance Abuse Treatment. *Inte­ grating Substance Abuse Treatment and Vocational Services.* Treatment Improvement Protocol (TIP) Series 38. HHS Publication No. (SMA) 00-3470. Rockville, MD: Sub­ stance Abuse and Mental Health Services Administration, *2000a.*

Center for Substance Abuse Treatment. *Sub­ stance Abuse Treatment for Persons With Child Abuse and Neglect Issues.* Treatment Improvement Protocol (TIP) Series 36. HHS Publication No. (SMA) 00-3357. Rockville, MD: Substance Abuse and Mental Health Services Administration, *2000b.*

Center for Substance Abuse Treatment. *Sub­ stance Abuse Treatment for Persons With HIV/AIDS.* Treatment Improvement Protocol (TIP) Series 37. HHS Publication No. (SMA) 00-3459. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2000c.

Center for Substance Abuse Treatment. Ben­ efits of Residential Substance Abuse Treat­ ment for Pregnant and Parenting Women: Highlights from a Study of 50 Demonstration Programs of the Center for Substance Abuse Treatment. Rockville, **MD:** Center for Sub­ stance Abuse Treatment 2001a.

Center for Substance Abuse Treatment. *A Providers Introduction To Substance Abuse Treatment For Lesbian, Gay, Bisexual, And Transgender Individuals.* HHS Publication No. (SMA) 01-3498. Rockville, MD: Sub­ stance Abuse and Mental Health Services Administration, 2001b.

Center for Substance Abuse Treatment. *Telling Their Stories: Rejfuctions Of The 11 Original Grantees That Piloted Residential Treatment For Women And Children For CSAT.* HHS Publication No. (SMA) 01-3529. Rockville, **MD:** Substance Abuse and **Mental** Health Services Administration, 2001c.

Center for Substance Abuse Treatment. *Help­ ing Yourself Heal: A Recovering Womans Guide To Coping With Childhood Abuse Issues.* HHS Publication No. (SMA) 03-3789. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2003a.

Center for Substance Abuse Treatment. *Lessons Learned: Residential Substance Abuse Treat­ ment For Women And Their Children.* HHS Publication No. (SMA) 03-3787. Rockville, MD: U.S. Department of Health and Hu­ man Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, 2003b.

Center for Substance Abuse Treatment. *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction.* Treat­ ment Improvement Protocol (TIP) Series

40. HHS Publication No. (SMA) 04-3939. Rockville, MD: Substance Abuse and Mental Health Services Administration, *2004a.*

Center for Substance Abuse Treatment.

*Substance Abuse Treatment and Family Therapy.* Treatment Improvement Protocol (TIP) Series 39. HHS Publication No. (SMA) 04-3957. Rockville, **MD:** Substance Abuse and Mental Health Services Administration, *2004b.*

Center for Substance Abuse Treatment.

*Medication-Assisted Treatment For Opioid Addiction In Opioid Treatment Programs.* Rockville, **MD:** Substance Abuse and Mental Health Services Administration, *2005a.*

Center for Substance Abuse Treatment. *Med­ ication-Assisted Treatment for Opioid Ad­ diction.* Treatment Improvement Protocol (TIP) Series 43. HHS Publication No. SMA 05-4048. Rockville, **MD:** Substance Abuse and Mental Health Services Administration, *2005b.*

Center for Substance Abuse Treatment. *Sub­ stance Abuse Treatment for Adults in the Criminal Justice System.* Treatment Im­ provement Protocol (TIP) Series 44. HHS Publication No. (SMA) 05-4056. Rockville, MD: Substance Almse and Mental Health Services Administration, *2005c.*

Center for Substance Abuse Treatment. *Sub­ stance Abuse Treatment: Group Therapy.* Treatment Improvement Protocol (TIP) Se­ ries 41. HHS Publication No. SMA 05-4056. Rockville, **MD:** Substance Abuse and Mental Health Services Administration, 2005d.

Center for Substance Abuse Treatment. *Suh­ stance Abuse Treatment for Persons with Co-Occurring Disorders.* Treatment Im­ provement Protocol (TIP) Series 42. HHS Publication No. SMA 05-3992. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005e.

Center for Substance Abuse Treatment. *Detoxi­ fication and Substance Abuse Treatment.*

Treatment Improvement Protocol (TIP) Se­ ries 45. HHS Publication No. SMA 06-4131. Rockville, MD: Substance Abuse and Mental Health Services Administration, *2006a.*

Center for Substance Abuse Treatment. *Sub­ stance Abuse: Administrative Issues in Intensive Outpatient Treatment.* Treatment Improvement Protocol (TIP) Series 46. HHS Publication No. SMA 06-4151. Rockville, MD: Substance Abuse and Mental Health Services Administration, *2006b.*

Center for Substance Abuse Treatment. *Sub­ stance Abuse: Clinical Issues in Intensive Outpatient Treatment.* Treatment Improve­ ment Protocol (TIP) Series 47. HHS Publica­ tion No. 06-4182. Rockville, MD: Substance Abuse and Mental Health Services Adminis­ tration, 2006c.

Center for Substance Abuse Treatment. State substance abuse treatment standards for women: A review of the current landscape. Prepared for Discussion at the NASADAD­ WTC 2007 Annual Meeting June 6, 2007,

Burlington, Vermont. 2007.

Center for Substance Abuse Treatment. *Manag­ ing Depressive Symptoms in Substance Abuse Clients During Early Recovery.* Treatment Improvement Protocol (TIP) Series 48. HHS Publication No. SMA 08-4353 Rockville,

**MD:** Substance Abuse and **Mental** Health Services Administration, 2008.

Center for Substance Abuse Treatment. *Ad­ dressing Suicidal Thoughts and Behaviors With Clients in Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Se­ ries 50. HHS Publication No. SMA 09-4381. Rockville, **MD:** Substance Abuse and Mental Health Services Administration, *2009a.*

Center for Substance Abuse Treatment. *Incor­ porating Alcohol Pharmacotherapies Into Medical Practice.* Treatment Improvement Protocol (TIP) Series 49. HHS Publication No. SMA 09-4380. Rockville, MD: Substance Abuse and Mental Health Services Adminis­ tration, *2009b.*

Center for Substance Abuse Treatment. *Improv­ ing Cultural Competence in Substance Abuse Treatment.* Treatment Improvement Proto­ col (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Adminis­ tration, in development *a.*

Center for Substance Abuse Treatment. *Man­ agement of Chronic Pain in People With Substance Use Disorders.* Treatment Im­ provement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration, in development *b.*

Center for Substance Abuse Treatment. *Relapse Prevention and Recovery in Substance Abuse Treatment Settings.* Treatment Improve­ ment Protocol (TIP) Series. Rockville, **MD:** Substance Abuse and Mental Health Services Administration, in development *c*

Center for Substance Abuse Treatment. *Sub­ stance Abuse Treatment: Addressing the Spe­ cific Needs of Women.* Treatment Improve­ ment Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration, in development *d.*

Center for Substance Abuse Treatment. *Sub­ stance Abuse Treatment with American Indi­ ans and Alaska Natives.* Treatment Improve­ ment Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration. In development *e.*

Center for Substance Abuse Treatment. *Sub­ stance Abuse Treatment and Men's Issues.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration, in development *f.*

Center for Substance Abuse Treatment. *Sub­ stance Abuse Treatment With People Who Are Homeless.* Treatment Improvement Pro­ tocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Adminis­ tration, in development *g.*

Center for Substance Abuse Treatment. *Sub­ stance Abuse Treatment and Trauma.* Treat­ ment Improvement Protocol (TIP) Series.

Rockville, **MD:** Substance Abuse and Mental Health Services Administration, in develop­ **ment** *h.*

Center for Substance Abuse Treatment. *Super­ vision and the Professional Development*

*of the Substance Abuse Counselor.* Treat­ ment Improvement Protocol (TIP) Series. Rockville, **MD:** Substance Abuse and Mental Health Services Administration, in develop­ ment *i.*

Center for Substance Abuse Treatment. *Viral Hepatitis and Substance Abuse.* Treatment Improvement Protocol (TIP) Series. Rock­ ville, MD: Substance Abuse and Mental Health Services Administration, in develop­ mentj.

Center on Alcoholism, *Substance Abiise and Addictions. Religious Practice and Beliefs Instrument.* Albuquerque, NM: University of New Mexico, 2004.

Centers for Disease Control and Prevention.

Public Health Service task force recommen­ dations for the use of antiretroviral drugs in pregnant women infected with HIV-1 for maternal health and for reducing perinatal HIV-1 transmission in the United States.

*Morbidity and Mortality Weekly Report*

47(RR-2):l-30, 1998.

Centers for Disease Control & Prevention.

Women and Smoking: A Report of the Sur­ geon General, 2001. *Pattern of Tobacco Use Among Women and Girls* - *Fact Sheet* Atlan­ ta, GA: Center for Disease Control & Pre­ vention, Office of Smoking and Health 2001.

Centers for Disease Control and Prevention. Drug-Associated HIV Transmission Contin­ ues in the United States. Atlanta, GA: 2002.

Centers for Disease Control and Prevention. Cigarette smoking among adults - United States, 2002. *MMWR* 53(20):427-446. Wash­

ington, D.C.: Centers for Disease Control and Prevention, 2004.

Centers for Disease Control and Prevention. HIV/AIDS among African Americans. *Fact Sheet* - *HIV/AIDS Among African Americans.* Atlanta, GA: Centers for Disease Control and Prevention (CDC) 2005.

Centers for Disease Control and Prevention. HIV/AIDS among Women. Atlanta, GA: Centers for Disease Control and Prevention, 2007a.

Centers for Disease Control and Prevention.

HIV/AIDS Surveillance Report, 2005: Cases of HIV infection and AIDS in the United States and Dependent Areas, 2005. Volume 17 Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2007b.

Centers for Disease Control and Prevention. Hepatitis C fact sheet. 2008. <http://cdc.gov/> hepatitis/hcv/pdfs/hepcgeneralfactsheet.pdf [Accessed October 2, 2008].

Chabrol, H., Teissedre, F., Saint-Jean, M., Teisseyre, N., Roge, B., and Mullet, E. Prevention and treatment of post-partum depression: A controlled randomized study on women at risk. *Psychological Medicine* 32(6):1039-1047, 2002.

Chamberlin, J., and Schene, **A.H.** A working definition of empowerment. *Psychiatric Re­ habilitation Journal* 20(4):43-46, 1997.

Chan, A.W., Pristach, E.A., Welte, J.W., and Russell, M. Use of the TWEAK test in screen­ ing for alcoholism/heavy drinking in three populations. *Alcoholism: Clinical* & *Experi­ mental Research* 17(6):1188-1192, 1993.

Chan, C.S. Issues of identity development among Asian-American lesbians and gay men. *Journal of Counseling and Develop­ ment* 68(1):16-20, 1989.

Chan, C.S. Don't ask, don't tell, don't know: The formation of a homosexual identity and sexual expression among Asian American lesbians. In: Greene, B., ed. *Ethnic And Cultural Diversity Among Lesbians And Gay Men.* Thousand Oaks, CA: Sage Publica­ tions, 1997. pp. 240-248.

Chang, G. Brief interventions for problem drinking and women. *Journal of Substance Abuse Treatment* 23(1):1-7, 2002.

Chang, G., Goetz, M.A., Wilkins-Haug, L., and Berman, S. A brief intervention for prenatal alcohol use: An in-depth look. *Journal of Substance Abuse Treatment* 18(4):365-369, 2000.

Chang, G., McNamara, T.K., Haimovici, F., and Hornstein, M.D. Problem drinking in women evaluated for infertility. *American Journal of Addiction* 15(2):174-179, 2006.

Chang, G., Wilkins-Haug, L., Berman, S., and Goetz, M.A. The TWEAK: Application in a prenatal setting. *Journal of Studies on Alco­ hol* 60(3):306-309, 1999.

Chang, G., Wilkins-Haug, L., Berman, S., Goetz, M.A., Behr, H., and Hiley, A. Alcohol use and pregnancy: Improving identification. *Obstetrics and Gynecology* 91(6):892-898, 1998.

Chang, P. Treating Asian/Pacific American ad­ dicts and their families. In: Krestan, J.-A., ed. *Bridges To Recovery: Addiction, Family Therapy, And Multicultural Treatment.* New York: Free Press, 2000. pp. 192-218.

Chang,Y.-Y.J. Comorbidity of depression and substance use disorders: The role of de­ pression as a risk factor for post-treatment relapse, 1997.

Chasnoff, I.J., McGourty, R.F., Bailey, G.W., Hutchins, E., Lightfoot, S.O., Pawson, L.L., Fahey, C., May, B., Brodie, P., McCulley,

L., and Campbell, J. The 4P's Plus screen for substance use in pregnancy: clinical ap­ plication and outcomes. *Journal of Perina­ tology* 25(6):368-374, 2005.

Chasnoff, I.J., Neuman, K., Thornton, C., and Callaghan, **M.A.** Screening for substance use in pregnancy: A practical approach for the primary care physician. *American Journal of Obstetrics and Gynecology* 184(4):752-758, 2001.

Chatham, L.R., Hiller, M.L., Rowan-Szal, G.A., Joe, G.W., and Simpson, D.D. Gender differences at admission and follow-up in a sample of methadone maintenance clients.

*Substance Use* & *Misuse* 34(8):1137-1165,

1999.

Chavkin, W., and Breitbart, V. Substance abuse and maternity: The United States as a case study. *Addiction* 92(9):1201-1205, 1997.

Chen, **H.,** Guarnaccia, **P.J.,** and Chung, **H.** Self-attention as a mediator of cultural influ­ ences on depression. *International Journal of Social Psychiatry* 49(3):192-203, 2003.

Chen, X., Burgdorf, K., Dowell, K., Roberts, T., Porowski, A., and Herrell, J.M. Fac­ tors associated with retention of drug abus­ ing women in long-term residential treat­ ment. *Evaluation and Program Planning* 27(2):205-212, 2004.

Chen, C.M., Yoon, Y.H., Yi, H.y., and Lu­ cas, D.L. Alcohol and hepatitis C mortal­ ity among males and females in the United States: A life table analysis. *Alcoholism: Clinical and Experimental Research* 31(2):285-292, 2007.

Cherry, D.K., and Woodwell, D.A. National Ambulatory Medical Care Survey: 2000 Sum­ mary. *Advance Data From Vital and Health Statistics, No.328* Hyattsville, MD: National Center for Health Statistics 2002.

Chilcoat, **H.D.,** and Breslau, N. Alcohol disor­ ders in young adulthood: Effects of transi­ tions into adult roles. *Journal of Health and Social Behavior* 37(4):339-349, 1996.

Child Welfare League of America. *Crack And Other Addictions: Old Realities And New Challenge For Child Welfare.* Washington, DC: Child Welfare League of America, 1990.

Child Welfare League of America. *Children at the Front: A Different View of the War on Alcohol and Drugs.* Washington, DC: Child Welfare League of America, 1992.

Chisholm, D., Rehm, J., Van, O.M., and Monteiro, M. Reducing the global burden of hazardous alcohol use: a comparative cost­ effectiveness analysis. *Journal of Studies on Alcohol* 65(6):782-793, 2004.

Choi, S., and Ryan, J.P. Co-occurring prob­ lems for substance abusing mothers in child welfare: Matching services to improve family reunification. *Children and Youth Services Review* 29(11):1395-1410, 2007.

Chou, S.P., Grant, B.F., and Dawson, D.A. Medical consequences of alcohol consump­ tion--United States, 1992. *Alcoholism: Clini­ cal and Experimental Research* 20(8):1423- 1429, 1996.

Chung, R.H., Kim, B.S., and Abreu, J.M. Asian American multidimensional accultura­ tion scale: development, factor analysis, reli­ ability, and validity. *Cultural Diversity and Ethnic Minority Psychology* 10(1):66-80, 2004.

Clark, J.J., Leukefeld, C., Godlaski, T., Brown, C., Garrity, J., and Hays, L. De­ veloping, implementing, and evaluating a treatment protocol for rural substance abus­ ers. *Journal of Rural Health* 18(3):396-406, 2002.

Claus, R.E., Orwin, R.G., Kissin, W., Krupski, A., Campbell, K., and Stark, K. Does gen­ der-specific substance abuse treatment for women promote continuity of care? *Journal of Substance Abuse Treatment* 32(1):27-39, 2007.

Cochran, S.D., Ackerman, D., Mays, V.M., and Ross, M.W. Prevalence of non-medical drug use and dependence among homosexually active men and women in the US population. *Addiction* 99(8):989-998, 2004.

Cochran, S.D., and Mays, V.M. Relation be­ tween psychiatric syndromes and behavior­ ally defined sexual orientation in a sample of the US population. *American Journal of Epidemiology* 151(5):516-523, 2000.

Cochran, S.D., Keenan, C., Schober, C., and Mays, **V.M.** Estimates of alcohol use and clinical treatment needs among homosexually active men and women in the U.S. popula­ tion. *Journal of Consulting and Clinical Psychology* 68(6):1062-1071, 2000.

Cochran, S.D., Mays, V.M., Alegria, M., Or­ tega, A.N., and Takeuchi, D. Mental health and substance use disorders among Latino and Asian American lesbian, gay, and bisexu­ al adults. *Journal of Consulting and Clinical Psychology* 75(5):785-794, 2007.

Cochran, S.D., Mays, V.M., Bowen, D., Gage, S., Bybee, D., Roberts, S.J., Goldstein, R.S., Robison, A., Rankow, E.J., and White, J. Cancer-related risk indicators and preventive screening behaviors among lesbi­ ans and bisexual women. *American Journal of Public Health* 91(4):591-597, 2001.

Cocozza, **J.J.,** Jackson, E.W., Hennigan, K., Morrissey, J.P., Reed, B.G., Fallot, R., and Banks, S. Outcomes for women with co-oc­ curring disorders and trauma: program-level effects. *Journal of Substance Abuse Treat­ ment* 28(2):109-119, 2005.

Cohen, J.B., Dickow, A., Horner, K., Zwe- ben, J.E., Balabis, J., Vandersloot, D., and Reiber, C. Abuse and violence history of men and women in treatment for metham­

phetamine dependence. *American Journal of Addiction* 12(5):377-385, 2003.

Cohen, L.R., and Hien, D.A. Treatment out­ comes for women with substance abuse and PTSD who have experienced complex

trauma. *Psychiatric Services* 57(1):100-106, 2006.

Cohen, L.S., Viguera, A.C., Bouffard, S.M., Nonacs, **R.M.,** Morabito, C., Collins, **M.H.,** and Ablon, **J**.S. Venlafaxine in the treatment of postpartum depression. *Journal of Clini­ cal Psychology* 62(8):592-596, 2001.

Cohen, **M.** *Counseling Addicted Women.* Thou­ sand Oaks, CA: Sage Publications, 2000.

Cohen, R.A., Hao, C., and Coriaty-Nelson, Z. Health insurance coverage: Estimates from the National Health Interview Survey, Janu­ ary - June 2004. Atlanta, GA: Centers for Disease Control and Prevention, 2004.

Cohen-Smith, D., and Severson, H.H. A com­ parison of male and female smokeless to­ bacco use. *Nicotine* & *Tobacco Research* 1(3):211-218, 1999.

Cohn, J.A. HIV-1 infection in injection drug users. *Infectious Disease Clinics of North America* 16(3):745-770, 2002.

Coleman, V.E. Lesbian battering: The rela­ tionship between personality and the per­ petration of violence. *Violence and Victims* 9(2):139-152, 1994.

Collins, R.L., and McNair, L.D. Minority women and alcohol use. *Alcohol Research* & *Health* 26(4):251-256, 2002.

Colorado Department of Human Services, and Alcohol and Drug Abuse Division (ADAD). Substance use disorder treatment rules. Den­ ver, CO: Colorado Department of Human Services, Alcohol and Drug Abuse Division (ADAD), 2006.

Comfort, M., and Kaltenbach, K. The psycho­ social history: An interview for pregnant and parenting women in substance abuse treat­ ment and research. In: Rahdert, E.R., ed. *Treatment For Drug-Exposed Women And Their Children: Advances In Research Meth­ odology.* NIDA Research Monograph 166.

NIH Publication No. 96-3632. Rockville, MD: National Institute on Drug Abuse, 1996. pp. 133-142.

Comfort, M., and Kaltenbach, K.A. Predictors of treatment outcomes for substance-abusing women: A retrospective study. *Substance Abuse* 21(1):33-45, 2000.

Comfort, M., Hagan, T., and Kaltenbach, K. *Psychosocial History.* Philadelphia, PA: Thomas Jefferson University, Jefferson Medical Center, Family Center, 1996.

Comfort, M., Loverro, **J.,** and Kaltenbach, K. A search for strategies to engage women **in** substance abuse treatment. *Social Work in Health Care* 31(4):59-70, 2000.

Comfort, M., Zanis, D.A., Whiteley, M.J., Kel­ ly-Tyler, A., and Kaltenbach, K.A. Assess­ ing the needs of substance abusing women: Psychometric data on the psychosocial his­ tory. *Journal of Substance Abuse Treatment* 17(1-2):79-83, 1999.

Connecticut Department of Mental Health and Addiction Services, Women's Services Prac­ tice Improvement Collaborative, compiled by David J. Berkowitz. *Treatment Guidelines: Gender Responsive Treatment Of Women With Substance Use Disorders.* January 23, 2007 Revision Hartford, CT: Connecticut Department of Mental Health and Addiction Services, 2007.

Conners, N.A., Bradley, R.H., Mansell, L.W., Liu, J.Y., Roberts, T.J., Burgdorf, K., and Herrell, **J.M.** Children of mothers with seri­ ous substance abuse problems: An accumula­ tion of risks. *American Journal of Drug and Alcohol Abuse* 30(1):85-100, 2004.

Conners, N.A., Grant, A., Crone, C.C., and Whiteside-Mansell, L. Substance abuse treatment for mothers: Treatment outcomes and the impact of length of stay. *Journal of Substance Abuse Treatment* 31(4):447--456, 2006.

Conway, **K.P.,** and Montoya, I.D. Symposium: What is the directionality of the onset of co­ morbid substance use and other psychiatric disorders? Bethesda, MD: National Institute on Drug Abuse, 2007.

Cooley, M.E., Blood, E., Hoskinson, R., and Garvey, A. Gender differences in smoking relapse. *Oncology Nursing Forum* 33(2):401- 402, 2006.

Corcos, M., Nezelof, S., Speranza, M., Topa, S., Girardon, N., Guilbaud, 0., Ta<;eb,

0., Bizouard, P., Halfon, 0., Venisse, J.L., Perez-Diaz, F., Flament, M., and Jeammet,

P. Psychoactive substance consumption in eating disorders. *Eating Behaviors* 2(1):27- 38, 2001.

Corliss, H.L., Grella, C.E., Mays, V.M., and Cochran, S.D. Drug use, drug severity, and help-seeking behaviors of lesbian and bi­ sexual women. *Journal of Womens Health (Larchmt.)* 15(5):556-568, 2006.

Corse, S.J., McHugh, **M.K.,** and Gordon, S.M. Enhancing provider effectiveness in treating pregnant women with addictions. *Journal*

*of Substance Abuse Treatment* 12(1):3-12,

1995.

Cottrell, **B.H.** Vaginal douching. *Journal of Ob­ stetric, Gynecologic, and Neonatal Nursing* 32(1):12-18, 2003.

Coughey, **K.,** Feighan, K., Cheney, **R.,** and Klein, G. Retention in an aftercare program for recovering women. *Substance Use and Misuse* 33(4):917-933, 1998.

Cournoyer, L.G., Brochu, S., Landry, M., and Bergeron, J. Therapeutic alliance, patient behaviour and dropout in a drug rehabilitation programme: the moderating effect of clinical subpopulations. *Addiction* 102(12):1960-1970, 2007.

Covington, S. A case for gender-responsive drug treatment. *Clinical Psychiatry News* 35(8):15, 2007.

Covington, S.S. *A Womans Way through the Twelve Steps.* Center City, MN: Hazelden, 1994.

Covington, S.S. Women, addiction, and sexu­ ality. In: Straussner, S.L.A., and Zelvin, E., eds. *Gender and Addictions: Men and Women in Treatment.* Northvale, NJ: Jason Aronson, 1997. pp. 71-95.

Covington, S.S. Women in prison: Approaches in the treatment of our most invisible popu­ lation. *Women* & *Therapy* 21(1):141-155, 1998.

Covington, S.S. *Helping Women Recover: A Program for Treating Addiction.* San Fran­ cisco: Jossey-Bass, 1999a.

Covington, S.S. *Helping Women Recover: A Program for Treating Addiction. Special Edition for Use in Correctional Settings.* San Francisco: Jossey-Bass, 1999b.

Covington, S.S. *Awakening Your Sexuality: A Guide for Recovering Women.* Center City, MN: Hazelden, 2000.

Covington, S.S. *A Womans Journey Home: Challenges for Female Offenders and Their Children.* Washington, DC: Urban Institute *2002a.*

Covington, S.S. Helping women recover: Creat­ ing gender-responsive treatment. In: Strauss­ ner, S.L.A., and Brown, S., eds. *Handbook of Women* '.s *Addiction Treatment: Theory and Practice.* San Francisco: Jossey-Bass, *2002b.* pp. 52-72.

Covington, S.S. *Beyond Trauma: A Healing Journey for Women: Facilitator'.s Guide.* Center City, Minnesota: Hazelden, *2003a.*

Covington, S.S. *Beyond Trauma: A Healing Journey for Women: Participant'.s Work­ book.* Center City, Minnesota: Hazelden, *2003b.*

Covington, S. S. *Women and Addiction: A Gender-Responsive Approach.* Clinical In­ novators Series. Center City, MN: Hazelden, 2007.

Covington, S.S. *Helping Women Recover: A Program for Treating Addiction.* (Rev. ed.) San Francisco: Jossey-Bass, 2008a.

Covington, S.S. *Helping Women Recover: A Program for Treating Addiction. Special Edition for Use in Correctional Settings.* (Rev. ed.) San Francisco: Jossey-Bass, 2008b.

Covington, S.S., and Bloom, B.E. Gendered justice: Women in the criminal justice sys­ tem. In: Bloom, B.E., ed. *Gendered Justice: Addressing the Female Offender.* Durham, NC: Carolina Academic Press, 2003. pp.

3-24.

Covington, S.S., and Surrey, J.L. The relation­ al model of women's psychological develop­ ment: Implications for substance abuse. In: Wilsnack, R.W., and Wilsnack, S.C., eds.

*Gender and Alcohol: Individual and Social*

*Perspectives.* New Brunswick, NJ: Rutgers Center of Alcohol Studies, 1997. pp. 335- 351.

Cowan, G., and Ullman, J.B. lngroup rejec­ tion among women: The role of personal inadequacy. *Psychology of Women Quarterly* 30(4):399-409, 2006.

Coyhis, **D.** Culturally specific addiction recov­ ery for Native Americans. In: Krestan, **J.,** ed. *Bridges To Recovery: Addiction, Family Therapy, And Multicultural Treatment.* New York: The Free Press, 2000. pp. 77-114.

Coyne, C.M., Jarrett, M.E., Burr, R.L., and Murphy, S.A. Women's physical and psycho­ logical symptoms during early phase recov­ ery from alcoholism: A longitudinal study.

*Journal of Addictions Nursing* 17(2):83-93,

2006.

Cramer, M. *Issues in the treatment of dual diagnosis: PTSD and substance abuse in women.* Presentation to DATA of Rhode Island, Providence, RI, October, 2000.

Cramer, M. Under the influence of uncon­ scious process: Countertransference in the treatment of PTSD and substance abuse in women. *American Journal of Psychotherapy* 56(2):194-210, 2002.

Crits-Christoph, P., Baranackie, K., Kurcias,

J. S., and Beck, A.**T.** Meta-analysis of thera­ pist effects in psychotherapy outcome stud­ ies. *Psychotherapy Research* 1(2):81-91, 1991.

Cuellar, I., Harris, L.C., and Jasso, **R. An** acculturation scale for Mexican American normal and clinical populations. *Hispanic Journal of Behavioral Sciences.* 2(3):199- 217, 1980.

Cuijpers, P., van Straten A., and Warmerdam,

L. Behavioral activation treatments of de­ pression: A meta-analysis. *Clinical Psychol­ ogy Review* 27(3):318-326, 2007.

Cunningham, J.A., Sobell, L.C., Gavin, D.R., Sobell, M.B., and Breslin, F.C. Assessing motivation for change: Preliminary develop­ ment and evaluation of a scale measuring the costs and benefits of changing alcohol or drug use. *Psychology of Addictive Behaviors* 11(2):107-114, 1997.

Curtis, C.E., Jason, L.A., Olson, B.D., and Ferrari, J.R. Disordered eating, trauma, and sense of community: Examining women in substance abuse recovery homes. *Women* & *Health* 41(4):87-100, 2005.

Cutrona, C.E., Cadoret, **R.J.,** Suhr, **J**.A., Rich­ ards, C.C., Troughton, E., Schutte, K., and Woodworth, G. Interpersonal variables **in** the prediction of alcoholism among adoptees: evidence for gene-environment interactions. *Comprehensive Psychiatry* 35(3):171-179,

1994.

Daley, M., Argeriou, M., and McCarty, **D.** Sub­ stance abuse treatment for pregnant women: A window of opportunity? *Addictive Behav­ iors* 23(2):239-249, 1998.

Dallam, S.J. Theidentification and management of self-mutilating patients in primary care.

*Nurse Practitioner* 22(5):151-165, 1997.

Dansky, B.S., Brewerton, T.D., and Kilpatrick,

D.G. Comorbidity of bulimia nervosa and alcohol use disorders: Results from the Na­ tional Women's Study. *International Journal of Eating Disorders* 27(2):180-190, 2000.

Dashe, J.S., Jackson, G.L., Olscher, D.A., Zane, E.H., and Wendel, G.D., Jr. Opioid detoxification in pregnancy. *Obstetrics and Gynecology* 92(5):854-858, 1998.

D'Avanzo, C., Dunn, P., Murdock, **J.,** and Naegle, M. Developing culturally informed strategies for substance-related interven­ tions. In: Naegle, M.A., and D'Avanzo, C.E., eds. *Addictions And Substance Abuse: Strat­ egies For Advanced Practice Nursing.* Upper Saddle River, NJ: Prentice Hall Health, 2001. pp. 59-74.

D'Avanzo, C.E., Frye, B., and Froman, R. Culture, stress and substance use **in** Cambo­ dian refugee women. *Journal of Studies on Alcohol* 55(4):420-426, 1994.

Davidson, P.R., and Parker, K.C. Eye move­ ment desensitization and reprocessing (EMDR): A meta-analysis. *Journal of Con­ sulting and Clinical Psychology* 69(2):305- 316, 2001.

Davis, T.M., Bush, K.R., Kivlahan, D.R., Dobie, D.J., and Bradley, K. Screening for substance abuse and psychiatric disorders among women patients in a VA Health Care System. *Psychiatric Services* 54:214-218, 2003.

Dawson, D.A., Grant, B.F., Chou, S.P., and Stinson, F.S. The impact of partner alcohol problems on women's physical and mental health. *Journal of Studies on Alcohol and Drugs* 68(1):66-75, 2007.

Day, N., Cornelius, M., Goldschmidt, L., Rich­ ardson, G., Robles, N., and Taylor, **P.** The effects of prenatal tobacco and marijuana use on offspring growth from birth through 3 years of age. *Neurotoxicology and Teratol­ ogy* 14(6):407-414, 1992.

Dayton, T. *Trauma and Addiction: Ending the Cycle of Pain Through Emotional Literacy.* Deerfield Beach, FL: Health Communica­ tions, 2000.

de Mello, M.F., de Jesus Mari, J., Bacaltchuk, J., Verdeli, **H.,** and Neugebauer, R. A sys­ tematic review of research findings on the ef­ ficacy of interpersonal therapy for depressive disorders. *European Archives of Psychiatry and Clinical Neuroscience* 255(2):75-82, 2005.

Dean, L., Meyer, **I.H.,** Robinson, K., Sell,

R.L., Sember, R., Silenzio, V.M.B., Bowen, D.J., Bradford, J., Rothblum, E., Scout, White, J., Dunn, P., Lawrence, A., Wolfe, D., and Xavier, **J.** Lesbian, gay, bisexual, and transgender health: Findings and con­ cerns. *Journal of the Gay and Lesbian Medi­ cal Association* 4(3):101-151, 2000.

Dempsey, P., Bird, D.C., and Hartley, D. Rural mental health and substance abuse. In: Rick­ etts, T.C., ed. *Rural Health in the United States.* New York: Oxford University Press, 1999. pp. 159-178.

DeNavas-Walt, C., Proctor, B.D., and Mills,

R.J. Income, Poverty, and Health Insur­ ance Coverage in the United States: 2003.

*U.S. Census Bureau, Current Population Reports, P60-226,* Washington, D.C.: U.S. Government Printing Office, 2004.

Dennerstein, L. *Factors associated with the ex­ perience of menopause and related therapy.* Presented at First World Congress on Wom­ en's Mental Health, Berlin, Germany, March 27-31,200la.

Dennerstein, L. *How does womens mental health differ from that of men?* Plenary speech presented at First World Congress on Women's Mental Health, Berlin, Germany, March 27-31, 2001b.

Derauf, C., LaGasse, L.L., Smith, L.M., Grant, P., Shah, R., Arria, A., Huestis, M., Haning,

W., Strauss, A., Grotta, S.D., **Liu, J.,** and

Lester, **B.M.** Demographic and psychosocial characteristics of mothers using methamphet­ amine during pregnancy: Preliminary results of the infant development, environment, and lifestyle study (IDEAL). *American Journal*

*of Drug and Alcohol Abuse* 33(2):281-289, 2007.

Derogatis, L.R., and Melisaratos, N. The Brief Symptom Inventory: An introductory report. *Psychological Medicine* 13(3):595-605, 1983.

Devaud, L.L., Risinger, F.O., and Selvage,

D. Impact of the Hormonal Milieu on the Neurobiology of Alcohol Dependence and Withdrawal. *Journal of General Psychology* 133(4):337-356, 2006.

DeVoe, D. Feminist and nonsexist counseling: Implications for the male counselor. *Journal of Counseling* & *Development* 69(1):33-36, 1990.

Diamant, A.L., Wold, C., Spritzer, K., and Gelberg, L. Health behaviors, health sta­ tus, and access to and use of health care: A population-based study of lesbian, bisexual, and heterosexual women. *Archives of Family Medicine* 9(10):1043-1051, 2000.

Dick, D.M., Pagan, J.L., Holliday, C., Viken, R., Pulkkinen, L., Kaprio, J., and Rose,

R.J. Gender differences in friends' influ­ ences on adolescent drinking: a genetic epidemiological study. *Alcoholism: Clinical*

& *Experimental Research* 31(12):2012-2019, 2007.

DiNitto, D.M., and Crisp, C. Addictions and women with major psychiatric disorders. In: Straussner, S.L.A., and Brown, S., eds. *The Handbook of Addiction Treatment for Women: Theory and Practice.* San Francis­ co: Jossey-Bass, 2002. pp. 423--450.

Dixit, A.R., and Crum, R.M. Prospective study of depression and the risk of heavy alcohol use in women. *American Journal of Psychia­ try* 157(5):751-758, 2000.

Dobie, D.J., Kivlahan, D.R., Maynard, C.,

Bush, K.R., Davis, T.M., and Bradley, K.A. Posttraumatic stress disorder in female vet­ erans: association with self-reported health problems and functional impairment. *Ar­ chives of Internal Medicine* 164(4):394--400, 2004.

Dole, V.P., and Nyswander, M.E. Rehabilitation of heroin addicts after blockade with metha­ done. *New York State Journal of Medicine* 66(15):2011-2017, 1966a.

Dole, V.P., Nyswander, M.E., and Kreek, M.J. Narcotic blockade. *Archives of Internal Medicine* 118(4):304-309, 1966b.

Donaldson, P.L. Perinatal drug and alcohol addiction: The role of the primary care provider. *Lippincotts Primary Care Practice* 4(3):349-358, 2000.

Dorgan, J.F., Baer, D.J., Albert, P.S., Judd,

J.T., Brown, E.D., Corle, D.K., Campbell,

W.S., Hartman, J.J., Tejpar, A.A., Clevi­ dence Beverly a., Giffen, C.A., Chandler, D.W., Stanczyk, F.Z., and Taylor, P.R. Serum hormones and the alcohol-breast can­ cer association in postmenopausal women.

*Journal of the National Cancer Institute*

93(9):710-715, 2001.

Drabble, L. Elements of effective services for women in recovery: Implications for clini­ cians and program supervisors. In: Under­ hill, B.L., and Finnegan, D.G., eds. *Chemi­ cal Dependency: Women At Risk.* New York: Harrington Park Press/Haworth Press, 1996. pp. 1-21.

Drabble, L., and Underhill, B. Elements of effective intervention and treatment for lesbians. In: Straussner, S.L.A., and Brown, S., eds. *The Handbook of Addiction Treat­ ment for Women: Theory and Practice.* San Francisco: Jossey-Bass, 2002. pp. 399-422.

Drake, R.E., Mercer-McFadden, C., Mueser,

K.T., McHugo, G.J., and Bond, G.R. Review of integrated mental health and substance abuse treatment for patients with dual disor­ ders. *Schizophrenia Bulletin* 24(4):589-608, 1998.

Dube, S.R., Miller, J.W., Brown, D.W., Giles,

W.H., Felitti, V.J., Dong, M., and Anda,

R.F. Adverse childhood experiences and the association with ever using alcohol and initi­ ating alcohol use during adolescence. *Jour­ nal of Adolescent Health* 38(4):444-10, 2006.

Duszynski, K.R., Nieto, F.J., and Valente, C.M. Reported practices, attitudes, and confidence levels of primary care physicians regarding patients who abuse alcohol and other drugs. *Maryland Medical Journal* 44(6):439-446, 1995.

Eaton, D.K., Kann, L., Kinchen, S., Shanklin, S., Ross, J., Hawkins, **J.,** Harris, W.A.,

Lowry, **R.,** McManus, T., Chyen, D., Lim, C., Brener, N.D., and Wechsler, **H.** *Youth Risk Behavior Surveillance--United States, 2007.* 57: No. SS-4:1-133. Atlanta, GA:

Centers for Disease Control and Prevention, 2008.

Eggert, J., Theobald, H., and Engfeldt, P. Ef­ fects of alcohol consumption on female fertil­ ity during an 18-year period. *Fertility and Sterility* 81(2):379-383, 2004.

Ehrmin, J.T. Unresolved feelings of guilt and shame in the maternal role with substance­ dependent African American women. *Jour­ nal of Nursing Scholarship* 33(1):47-52, 2001.

El-Bassel, N., Gilbert, L., Frye, V., Wu, E., Go, H., Hill, J., and Richman, B.L. Physi­ cal and Sexual Intimate Partner Violence Among Women in Methadone Maintenance Treatment. Source. *Psychology of Addictive Behaviors.* 18(2):180-183, 2004.

El-Bassel, N., Gilbert, L., Wu, E., Go, H., and **Hill, J.** Relationship Between Drug Abuse and Intimate Partner Violence: A Longitudi­ nal Study Among Women Receiving Metha­ done. *American Journal of Public Health* 95(3):465-470, 2005.

Eliason, M.J., and Skinstad, A.H. Drug and alcohol intervention for older women: A pilot study. *Journal of Gerontological Nursing* 27(12):18-24, 2001.

Ellickson, P.L., Hays, R.D., and Bell, R.M. Stepping through the drug use sequence: Longitudinal scalogram analysis of initia­ tion and regular use. *Journal of Abnormal Psychology* 101(3):441-451, 1992.

Elliott, D.E., Bjelajac, P., Fallot, R.D., Markoff, L.S., and Reed, B.G. Trauma­ informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychol­ ogy* 33(4):461-477, 2005.

El-Mohandes, A., Herman, A.A., Nabil El­ Khorazaty, M., Kaua, P.S., White, D., and Grylack, L. Prenatal care reduces the impact of illicit drug use on perinatal outcomes.

*Journal of Perinatology* 23(5):354-360,

2003.

Epstein, E.E., Fischer-Elber, K., and Al­ Otaiba, Z. Women, aging, and alcohol use disorders. *Journal of Women and Aging* 19(1-2):31-48, 2007.

Evans, J., Hahn, J., Page-Shafer, K., Lum, P., Stein, E., Davidson, P., and Moss, A. Gender differences in sexual and injection risk behavior among active young injection

drug users in San Francisco (the UFO study). *Journal of Urban Health* 80(1):137-146, 2003.

Evans, K., and Sullivan, **J.M.** *Treating Addict­ ed Survivors of Trauma.* New York: Guilford Press, 1995.

Evans, S.M. The role of estradiol and proges­ terone in modulating the subjective effects of stimulants in humans. *Experimental and Clinical Psychopharmacology* 15(5):418-

426, 2007.

Evans, S.M., and Foltin, R.W. Exogenous pro­ gesterone attenuates the subjective effects of smoked cocaine **in** women, but not in men. *Neuropsychopharmacology* 31(3):659-674,

2006.

Evans, S.M., Haney, M., and Foltin, **R.W.** The effects of smoked cocaine during the follicu­ lar and luteal phases of the menstrual cycle in women. *Psychopharmacology* 159(4):397- 406, 2002.

Evans-Campbell, T. Historical trauma in Ameri­ can Indian/Native Alaska communities: A multilevel framework for exploring impacts on individuals, families, and communities.

*Journal of Interpersonal Violence* 23(3):316-

338, 2008.

Evans-Campbell, T., Fredriksen-Goldsen, **K.I.,** Walters, **K.L.,** and Stately, A. Caregiving experiences among American Indian two­ spirit men and women: Contemporary and historical roles. *Journal of Gay* & *Lesbian Social Services: Issues in Practice, Policy* & *Research* 18(3-4):75-92, 2005.

Ewing, H. *A Practical Guide to Intervention in Health and Social Services with Pregnant and Postpartum Addicts and Alcoholics: Theoretical Framework, Brief Screening Tool, Key Interview Questions, and Strate­ gies for Referral to Recovery Resources.*

State of California Grant for Training and Cross-Training in Health, Social Services, and Alcohol/Drug Services, 1990.

Appendix A: Bibliography

Ewing, J .A. Detecting alcoholism. The CAGE questionnaire. *JAMA: The Journal of the American Medical Association* 252(14):1905- 1907, 1984.

Eyler, F.D., and Behnke, M. Early development of infants exposed to drugs prenatally. *Clin­ ics in Perinatology* 26(1):107-150, vii, 1999.

Eyler, F.D., Behnke, M., Garvan, C.W., Woods, N.S., Wobie, K., and Conlon, M. Newborn evaluations of toxicity and withdrawal relat­ ed to prenatal cocaine exposure. *Neurotoxi­ cology and Teratology* 23(5):399-411, 2001.

Fals-Stewart, W., Birchler, G.R., and O'Farrell, T.J. Drug-abusing patients and their intimate partners: Dyadic adjustment, relationship stability, and substance use.

*Journal of Abnormal Psychology* 108(1):11-

23, 1999.

Fals-Stewart, W., O'Farrell, **T.J.,** Birchler, G.R., Cordova, J., and Kelley, M.L. Be­ havioral couples therapy for alcoholism and drug abuse: Where we've been, where we are, and where we're going. *Journal of Cog­ nitive Psychotherapy* 19(3):229-246, 2005.

Federal lnteragency Forum on Aging-Related Statistics. *Older Americans 2004: Key In­ dicators of Well-being.* November. Federal lnteragency Forum on Aging-Related Sta­ tistics. Washington, D.C.: U.S. Government Printing Office, 2004.

Feinberg, F. Substance-abusing mothers and their children: Treatment for the family. In: Combrinck-Graham, L., ed. *Children in Families at Risk: Maintaining the Connec­ tions.* New York: Guilford Press, 1995. pp. 228-247.

Felitti, V.J., Anda, R.F., Nordenberg, D., Wil­ liamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P., and Marks, J.S. Relationship of childhood abuse and household dysfunc­

tion to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *American Journal of Preven­ tive Medicine* 14(4):245-258, 1998.

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Fernandez-Sola, J., and Nicolas-Arfelis, J.M. Gender differences in alcoholic cardio­ myopathy. *The Journal of Gender-Specific Medicine: JGSM: The Official Journal of the Partnership for Women's Health at Colum­ bia.* 5(1):41--47, 2002.

Ferreyra, N. Substance abuse and women with disabilities. Barker, L. T., Magill, K., MacK­ innon, J. Dougal., Ridley, B., and Freeman,

A. Cupolo. *Practitioner's Guide To Primary Care For Women With Physical Disabilities.* Oakland, CA: Berkeley Policy Associates and Alta Bates Summit Medical Center, 2005.

Fetzer Institute/National Institute on Aging Workgroup. *Multidimensional Measure­ ment Of Religiousness/Spirituality For Use In Health Research: A Report Of The Fetzer Institute/National Institute On Aging Work­ group.* Kalamazoo, **Ml:** Fetzer Institute, 1999.

Fetzer Institute/National Institute on Aging Workgroup. *Multidimensional Measure­ ment Of Religiousness/Spirituality For Use In Health Research: A Report of the Fetzer Institute/National Institute on Aging Work­ group.* Kalamazoo, MI: Fetzer Institute, 2003.

Fields, J., and Casper, L.M. America's Families and Living Arrangements. *Current Popula­ tion Reports* March 2000. P20-537 Washing­ ton, DC: U.S. Census Bureau, 2000.

Fillmore, **K.M.,** Leino, E.V., Motoyoshi, M., Shoemaker, C., Terry, **H.,** Ager, C.R., and Ferrer, **H.P.** Patterns and trends in women's and men's drinking. In: Wilsnack, R.W., and Wilsnack, S.C., eds. *Gender and Alcohol: Individual and Social Perspectives.* New Brunswick, NJ: Rutgers Center of Alcohol Studies, 1997. pp. 21--48.

Finch, B.K., Kolody, B., and Vega, W.A. Per­ ceived discrimination and depression among Mexican-origin adults in California. *Journal of Health and Social Behavior* 41(3):295- 313, 2000.

Finkelhor, D., Hotaling, G., Lewis, I.A., and Smith, C. Sexual abuse in a national survey of adult men and women: Prevalence, char­ acteristics, and risk factors. *Child Abuse and Neglect* 14(1):19-28, 1990.

Finkelstein, N. The relational model. In: *Pregnancy and Exposure to Alcohol and Other Drug Use.* CSAP Technical Report 7. Rockville, MD: Center for Substance Abuse Prevention, 1993a. pp. 47-59.

Finkelstein, N. Treatment programming for alcohol and drug-dependent pregnant wom­ en. *International Journal of the Addictions* 28(13):1275-1309, 1993b.

Finkelstein, N. Treatment issues for alcohol­ and drug-dependent pregnant and parenting women. *Health* & *Social Work* 19(1):7-15, 1994.

Finkelstein, N. Using the relational model as a context for treating pregnant and parenting chemically dependent women. In: Underhill, B.L., and Finnegan, D.G., eds. *Chemical Dependency: Women at Risk.* New York: Harrington Park Press/Haworth Press, 1996. pp. 23--44.

Finkelstein, N., Brown, **K.N.,** and Laham, C.Q. Alcoholic mothers and guilt: Issues for care­ givers. *Alcohol Health and Research World* 6(1):45--49, 1981.

Finkelstein, N., Kennedy, C., Thomas, K., and Kearns, **M.** *Gender-Specific Substance Abuse Treatment.* Rockville, **MD:** Center for Sub­ stance Abuse Prevention, 1997.

Finkelstein, N., VandeMark, N., Fallot, R., Brown, V., Cadiz, S., and Heckman, S. Enhancing substance abuse recovery through integrated trauma treatment. Sarasota, FL: National Trauma Consortium, 2004.

Fiorentine, R., and Anglin, M.D. Does increas­ ing the opportunity for counseling increase the effectiveness of outpatient drug treat­ ment? *American Journal of Drug and Alco­ hol Abuse* 23(3):369-382, 1997.

Fiorentine, R., Anglin, **M.D.,** Gil-Rivas, V., and Taylor, E. Drug treatment: Explaining the gender paradox. *Substance Use and Misuse* 32(6):653-678, 1997.

Fischer, G., Ortner, R., Rohrmeister, K., Jagsch, **R.,** Baewert, A., Langer, M., and Aschauer, **H.** Methadone versus buprenor­ phine in pregnant addicts: A double-blind, double-dummy comparison study. *Addiction* 101(2):275-281, 2006.

Fitzgerald, L.F., and Harmon, L.W. Women's career development: A postmodern update. In: Leong, F.T.L., and Barak, A., eds. *Con­ temporary Models In Vocational Psychology: A Volume In Honor Of Samuel H. Osipow.*

0-8058-2666-1 (hardcover); 0-8058-2667-X

(paperback). Lawrence Erlbaum Associates Publishers: Mahwah, 2001. pp. 207-230.

Fitzgerald, L.F., Fassinger, R.E., and Betz,

N.E. Theoretical advances in the study of women's career development. In: Walsh, W.B., and Osipow, S.H., eds. *Handbook Of Vocational Psychology: Theory, Research, And Practice (2nd ed.).* Contemporary top­ ics in vocational psychology. 0-8058-1374-8 (hardcover). Lawrence Erlbaum Associates, 1995. pp. 67-109.

Fitzsimons, H.E., Tuten, M., Vaidya, V., and Jones, H.E. Mood disorders affect drug treatment success of drug-dependent preg­ nant women. *Journal of Substance Abuse Treatment* 32(1):19-25, 2007.

Flannery, B., Fishbein, **D.,** Krupitsky, E., Lan­ gevin, D., Verbitskaya, E., Bland, C., Bolla, **K.,** Egorova, V., Bushara, N., Tsoy, M., and Zvartau, E. Gender differences in neurocog­ nitive functioning among alcohol-dependent Russian patients. *Alcoholism: Clinical* & *Experimental Research* 31(5):745-754, 2007.

Flensborg-Madsen, T., Knop, J., Mortensen, E.L., Becker, U., and Gronbaek, M. Amount of alcohol consumption and risk of develop­ ing alcoholism **in** men and women. *Alcohol and Alcoholism* 42(5):442-447, 2007.

Flores, E., Tschann, **J.M.,** Dimas, **J.M.,**

Bachen, E.A., Pasch, L.A., and de Groat,

C.L. Perceived discrimination, perceived stress, and mental and physical health among Mexican-origin adults. *Hispanic Journal of Behavioral Sciences* 30(4):401-424, 2008.

Foa, E.B., and Rothbaum, B.O. *Treating the Trauma of Rape: Cognitive-Behavioral Therapy for PTSD.* New York: Guilford Press, 1998.

Foa, E.B., Hembree, E.A., and Rothbaum,

B.O. *Prolonged Exposure Therapy For PTSD: Emotional Processing Of Traumatic Experiences: Therapist Guide.* Treatments that work. Oxford University Press: New York, 2007.

Ford, J., Kasimer, N., MacDonald, M., and Savill, G. *Trauma Adaptive Recovery Group Education and Therapy (TARGET): Partici­ pant Guidebook and Leader Manual.* Farm­ ington, CT: University of Connecticut Health Center, 2000.

Fortenberry, **J.D.,** McFarlane, M., Bleakley, A., Bull, S., Fishbein, M., Grimley, D.M., Malotte, C.K., and Stoner, B.P. Relation­ ships of stigma and shame to gonorrhea and HIV screening. *American Journal of Public Health* 92(3):378-381, 2002.

Frajzyngier, V., Neaigus, A., Gyarmathy, V.A., Miller, M., and Friedman, S.R. Gender dif­ ferences in injection risk behaviors at the first injection episode. *Drug and Alcohol Dependence* 89(2-3):145-152, 2007.

Frank, D.A., Augustyn, M., Knight, W.G., Pell, T., and Zuckerman, B. Growth, de­ velopment, and behavior in early childhood following prenatal cocaine exposure. *Jour­ nal of the American Medical Association* 285(12):1613-1625, 2001.

Frank, J.B., Weihs, K., Minerva, E., and Lieberman, D.Z. Women's mental health in primary care: Depression, anxiety, somatiza­ tion, eating disorders, and substance abuse. *Medical Clinics of North America* 82(2):359- 389, 1998.

Franklin, T.R., Ehrman, R., Lynch, K.G.,

Harper, D., Sciortino, N., O'Brien, C.P., and Childress, A.R. Menstrual cycle phase at quit date predicts smoking status **in** an NRT treatment trial: A retrospective analy­ sis. *Journal of Women's Health (15409996)* 17(2):287-292, 2008.

Franko, D.L., Dorer, D.J., Keel, P.K., Jackson, S., Manzo, M.P., and Herzog, D.B. How do eating disorders and alcohol use disorder influence each other? *International Journal of Eating Disorders* 38(3):200-207, 2005.

French, G.M., Groner, **J.A.,** Wewers, M.E., and Ahijevych, **K.** Staying smoke free: An intervention to prevent postpartum relapse. *Nicotine* & *Tobacco Research* 9(6):663-670, 2007.

Frezza, M., di Padova, C., Pozzato, G., Ter­ pin, M., Baraona, E., and Lieber, C.S. High blood alcohol levels in women: The role of decreased gastric alcohol dehydrogenase activity and first-pass metabolism. *New England Journal of Medicine* 322(2):95-99, 1990.

Fried, P.A., and Smith, A.M. A literature re­ view of the consequences of prenatal mari­ huana exposure: An emerging theme of a deficiency in aspects of executive function. *Neurotoxicology and Teratology* 23(1):1-11, 2001.

Fullilove, M.T., Fullilove, R.E., Smith, M., and Winkler, K. Violence, trauma, and post­ traumatic stress disorder among women drug users. *Joiirnal of Traumatic Stress* 6(4):533- 543, 1993.

Funkhouser, E., Pulley, L., Lueschen, G., Costello, C., Hook, E., III, andVermund,

S.H. Douching beliefs and practices among black and white women. *Journal of Wom­ en's Health and Gender-Based Medicine* 11(1):29-37, 2002.

Galbraith, S. *And So I Began to Listen to Their Stories: Working with Women in the Crimi­ nal Justice System.* Delmar, NY: National Gains Center, 1998.

Gale, T.C., White, J.A., and Welty, T.K. Differ­ ences in detection of alcohol use in a prenatal population (on a Northern Plains Indian Reservation) using various methods of ascer­ tainment. *South Dakota Journal of Medicine* 51(7):235-240, 1998.

Galea, S., and Vlahov, D. Social determinants and the health of drug users: Socioeconomic status, homelessness, and incarceration.

*Public Health Reports* 117 Suppl l:Sl35- Sl45, 2002.

Galen, L.W., Brower, K.J., Gillespie, B.W., and Zucker, R.A. Sociopathy, gender, and treat­ ment outcome among outpatient substance abusers. *Drug and Alcohol Dependence* 61(1):23-33, 2000.

Garner, D.M., Olmstead, M.P., Bohr, Y., and Garfinkel, P.E. The Eating Attitudes Test: Psychometric features and clinical corre­ lates. *Psychological Medicine* 12:871-878, 1982.

Garner, D.M., Rosen, L.W., and Barry, D. Eating disorders among athletes: Research and recommendations. *Child and Adoles­ cent Psychiatric Clinics of North America* 7(4):839-857, 1998.

Gary, L.E., and Littlefield, M.B. The protective factor model: Strengths-oriented prevention for African-American families. In: Bris­ bane, **F.L.,** Epstein, L.G., Pacheco, G., and Quinlan, J.W., eds. *Cultural Competence*

*for Health Care Professionals Working with African-American Communities: Theory and Practice.* CSAP Cultural Competence Series

7. HHS Publication No. (SMA) 98-3238. Rockville, MD: Center for Substance Abuse Prevention, 1998. pp. 81-105.

Gavaler, J.S., andArria, A.M. Increased susceptibility of women to alcoholic liver disease: Artifactual or real? In: Hall, **P.M.,** ed. *Alcoholic Liver Disease: Pathology and Pathogenesis.* 2nd ed. London, UK: Edward Arnold, 1995. pp. 123-133.

Gear, R.W., Gordon, N.C., Heller, P.H., Paul, S., Miaskowski, C., and Levine, J.D. Gender difference in analgesic response to the kappa­ opioid pentazocine. *Neuroscience Letters* 205(3):207-209, 1996.

Gee, G.C. A Multilevel Analysis of the Rela­ tionship Between Institutional and Indi­ vidual Racial Discrimination and Health Status. *American Journal of Public Health* 92(4):615-623, 2002.

Gehart, D.R., and Lyle, R.R. Client experience of gender in therapeutic relationships: an interpretive ethnography. *Family Process* 40(4):443-458, 2001.

George, W.H., Gournic, S.J., and McAfee, M.P. Perceptions of postdrinking female sexuality: Effects of gender, beverage choice, and drink payment. *Journal of Applied Social Psychol­ ogy* 18(15, Pt 1):1295-1317, 1988.

Giglia, R., and Binns, C. Alcohol and lactation: A systematic review. *Nutrition* & *Dietetics* 63:103-116, 2006.

Gilbert, **M.J.** Acculturation and changes **in** drinking patterns among Mexican-American women: Implications for prevention. *Alcohol Health and Research World* 15(3):234-238, 1991.

Gilbert, M.J., and Collins, R.L. Ethnic varia­ tion in women's and men's drinking. In: Wilsnack, R.W., and Wilsnack, S.C., eds. *Gender and Alcohol: Individual and Social Perspectives.* New Brunswick, NJ: Rutgers Center of Alcohol Studies, 1997. pp. 357- 378.

Gilligan, C. *In a Different Voice: Psychological Theory and Womens Development.* Cam­ bridge, MA: Harvard University Press, 1982.

Gilligan, C., Lyons, N., Hanmer, T.J., and Emma Willard School. *Making Connections:*

*The Relational Worlds of Adolescent Girls at Emma Willard School.* Cambridge, Mass: Harvard University Press, 1990.

Gilman, S.E., Cochran, S.D., Mays, **V.M.,** Hughes, M., Ostrow, D., and Kessler, R.C. Risk of psychiatric disorders among indi­ viduals reporting same-sex sexual partners in the National Comorbidity Survey. *American Journal of Public Health* 91(6):933-939, 2001.

Gil-Rivas, V., Fiorentine, R., and Anglin, M.D. Sexual abuse, physical abuse, and posttrau­ matic stress disorder among women partici­ pating in outpatient drug abuse treatment. *Journal of Psychoactive Drugs* 28(1):95-102, 1996.

Gil-Rivas, V., Fiorentine, R., Anglin, M.D., and Taylor, E. Sexual and physical abuse: Do they compromise drug treatment outcomes? *Journal of Substance Abuse Treatment* 14(4):351-358, 1997.

Gim Chung, R.H., Kim, B.S.K., and Abreu,

J.M. Asian American Multidimensional Acculturation Scale: Development, Factor Analysis, Reliability, and Validity. *Cultural Diversity and Ethnic Minority Psychology* 10(1):66-80, 2004.

Gloria, A.M., and Peregoy, **J.J.** Counseling Latino alcohol and other substance users/ abusers: Cultural considerations for counsel­ ors. *Journal of Substance Abuse Treatment* 13(2):119-126, 1996.

Goldberg, B. *A Framework for Systems Change: Evaluation of the Milwaukee Fam­ ily Services Coordination Initiative.* Madi­ son, WI: Wisconsin Department of Health and Family Services, Division of Supportive Living, Bureau of Substance Abuse Services, 2000.

Goldschmidt, L., Day, N.L., and Richardson,

G.A. Effects of prenatal marijuana exposure on child behavior problems at age 10. *Neu­ rotoxicology and Teratology* 22(3):325-336, 2000.

Goode, T.D., Dunne, C., and Bronheim, S.M. *The Evidence Base for Cultural and Linguis­ tic Competency in Health Care.* October New York, NY: The Commonwealth Fund 2006.

Gopaul-McNicol, S.A., and Brice-Baker, J. *Cross-Cultural Practice: Assessment, Treat­ ment, and Training.* New York: John Wiley & Sons, 1998.

Gordon, M.T., and Riger, S. *The Female Fear.*

New York: The Free Press, 1989.

Gottheil, E., Sterling, R.C., and Weinstein, S.P. Outreach engagement efforts: Are they worth the effort? *American Journal of Drug and Alcohol Abuse* 23(1):61-66, 1997.

Graham, K., Massak, A., Demers, A., and Rehm, J. Does the association between alco­ hol consumption and depression depend on how they are measured? *Alcoholism: Clinical* & *Experimental Research* 31(1):78-88, 2007.

Grant, B.F., Dawson, D.A., Stinson, F.S., Chou, S.P., Dufour, M.C., and Pickering,

R.P. The 12-Month prevalence and trends in DSM-TR-IV alcohol abuse and dependence. *Alcohol Research* & *Health* 29(2):79-91, 2006.

Grant, B.F., Stinson, F.S., Hasin, D.S., Daw­

son, D.A., Chou, S.P., and Anderson, K. Immigration and lifetime prevalence of DSM­ IV Psychiatric disorders among Mexican Americans and Non-Hispanic Whites in the United States: Results from the National Epi­ demiologic Survey on Alcohol and Related Conditions. *Archives of General Psychiatry* 61(12):1226-1233, 2004.

Gray, M., and Littlefield, M.B. Black women and addiction. In: Straussner, S.L.A., and Brown, S., eds. *The Handbook of Addiction Treatment for Women: Theory and Prac­ tice.* San Francisco: Jossey-Bass, 2002. pp. 301-322.

Grayson, C.E., and Nolen-Hoeksema, S. Mo­ tives to drink as mediators between child­ hood sexual assault and alcohol problems in adult women. *Journal of Traumatic Stress* 18(2):137-145, 2005.

Green, C.A., Polen, M.R., Dickinson, D.M., Lynch, F.L., and Bennett, M.D. Gender dif­ ferences in predictors of initiation, retention, and completion in an HMO-based substance abuse treatment program. *Journal of Sub­ stance Abuse Treatment* 23(4):285-295, 2002.

Green, C.A., Polen, M.R., Lynch, F.L., Dick­ inson, D.M., and Bennett, M.D. Gender differences in outcomes in an HMO-based substance abuse treatment program. *Journal of Addictive Diseases.* 23(2):47-70, 2004.

Green, J.H. Fetal Alcohol Spectrum Disorders: understanding the effects of prenatal alcohol exposure and supporting students. *J Sch Health* 77(3):103-108, 2007.

Greene, B. Ethnic minority lesbians and gay men: Mental health and treatment issues. In: Greene, B., ed. *Ethnic and Cultural Diver­ sity Among Lesbians and Gay Men.* Thou­ sand Oaks, CA: Sage Publications, 1997. pp. 216-239.

Greenfeld, L.A., and Snell, T.L. *Women Offend­ ers.* Bureau of Justice Statistics Special Re­ port. NCJ175688. Washington, DC: Bureau of Justice Statistics, 1999.

Greenfield, L., Burgdorf, K., Chen, X., Po­ rowski, A., Roberts, T., and Herrell, **J.** Ef­ fectiveness of long-term residential substance abuse treatment for women: findings from three national studies. *American Journal*

*of Drug and Alcohol Abuse* 30(3):537-550, 2004.

Greenfield, S.F. Women and substance use dis­ orders. In: Jensvold, M.F., and Halbreich, U., eds. *Psychopharmacology and Women: Sex, Gender, and Hormones.* Washington, DC: American Psychiatric Press, 1996. pp. 299-321.

Greenfield, S.F., and O'Leary, G. Sex differ­ ences in substance use disorders. In: Lewis­ Hall, F., and Williams, T.S., eds. *Psychiatric Illness in Women: Emerging Treatments and Research.* Washington, DC: American Psy­ chiatric Publishing, Inc, 2002. pp. 467-533.

Greenfield, S.F., Brooks, A.J., Gordon, S.M., Green, C.A., Kropp, F., McHugh, R.K., Lincoln, M., Hien, D., and Miele, G.M. Substance abuse treatment entry, reten­ tion, and outcome in women: A review of the literature. *Drug and Alcohol Dependence* 86(1):1-21, 2007a.

Greenfield, S.F., Trucco, E.M., McHugh, R.K., Lincoln, M., and Gallop, R.J. TheWomen's Recovery Group Study: a Stage I trial of women-focused group therapy for substance use disorders versus mixed-gender group drug counseling. *Drug and Alcohol Depen­ dence* 90(1):39-47, 2007b.

Grella, C.E. Background and overview of mental health and substance abuse treatment systems: Meeting the needs of women who are pregnant or parenting. *Journal of Psychoac­ tive Drugs* 28(4):319-343, 1996.

Grella, C.E. Services for perinatal women with substance abuse and mental health disor­ ders: The unmet need. *Journal of Psychoac­ tive Drugs* 29(1):67-78, 1997.

Grella, C.E. Women in residential drug treat­ ment: Differences by program type and preg­ nancy. *Journal of Health Care for the Poor and Underserved* 10(2):216-229, 1999.

Grella, C.E., and Joshi, V. Gender differences in drug treatment careers among clients in the national Drug Abuse Treatment Outcome Study. *American Journal of Drug and Alco­ hol Abuse* 25(3):385-406, 1999.

Grella, C.E., Annon, **J.J.,** and Anglin, **M.D.** Ethnic differences in HIV risk behaviors, self-perceptions, and treatment outcomes among women in methadone maintenance treatment. *Journal of Psychoactive Drugs* 27(4):421-433, 1995.

Grella, C.E., Joshi, V., and Hser, Y.I. Program variation in treatment outcomes among women in residential drug treatment. *Evalu­ ation Review* 24(4):364--383, 2000.

Grella, C.E., Scott, C.K., and Foss, M.A. Gender differences in long-term drug treat­ ment outcomes in Chicago PETS. *Journal of Substance Abuse Treatment* 28(Suppll):S3- Sl2, 2005.

Grice, D.E., Brady, K.T., Dustan, L.R., Mal­ colm, R., and Kilpatrick, D.G. Sexual and physical assault history and posttraumatic stress disorder in substance-dependent individuals. *American Journal on Addictions* 4(4):297-305, 1995.

Grieco, E.M. The Native Hawaiian and Other Pacific Islander Population: 2000. *Census 2000* BriefWashington, DC: U.S. Census Bureau 2001.

Griffin, M.L., Mendelson, J.H., Mello, N.K., and Lex, B.W. Marihuana use across the menstrual cycle. *Drug and Alcohol Depen­ dence* 18(2):213-224, 1986.

Griffiths, E.J., Lorenz, R.P., Baxter, S., and Talon, N.S. Acute neurohumoral response to electroconvulsive therapy during pregnancy: A case report. *Journal of Reproductive Medicine* 34(11):907-911, 1989.

Grosenick, J.K., and Hatmaker, C.M. Percep­ tions of the importance of physical setting in substance abuse treatment. *Journal of Sub­ stance Abuse Treatment* 18(1):29-39, 2000.

Gross, M., and Brown, V. Outreach to injec­ tion drug-using women. In: Brown, B.S., and Beschner, **G.M.,** eds. *Handbook on Risk of AIDS: Injection Drug Users and Sexual Partners.* Westport, CT: Greenwood Press, 1993. pp. 445-463.

Gruber, K., Fleetwood, T., and Herring, M. In­ home continuing care services for substance affected families: The Bridges Program.

*Social Work* 46(3):267-277, 2001.

Grucza, R.A., Bucholz, **K.K.,** Rice, J.P., and Bierut, L.J. Secular trends in the lifetime prevalence of alcohol dependence in the United States: a re-evaluation. *Alcohol­ ism: Clinical* & *Experimental Research* 32(5):763-770, 2008.

Gutierres, S.E., and Todd, M. The impact of childhood abuse on treatment outcomes of substance users. *Professional Psychology: Research and Practice* 28(4):348-354, 1997.

Hagedorn, H., Dieperink, E., Dingmann, D., Durfee, J., Ho, S.B., Isenhart, C., Rett­ mann, N., and Willenbring, M. Integrating hepatitis prevention services into a substance use disorder clinic. *Journal of Substance Abuse Treatment* 32(4):391-398, 2007.

Hall, J.M. Lesbians in alcohol recovery surviv­ ing childhood sexual abuse and parental substance misuse. *International Journal of Psychiatric Nursing Research* 5(1):507-515, 1999.

Hall, J.M. Core issues for female child abuse survivors in recovery from substance misuse. *Qualitative Health Research* 10(5):612-631, 2000.

Hall, P.M. Pathological spectrum of alcoholic liver disease. In: Hall, P.M., ed. *Alcoholic Liver Disease: Pathology and Pathogenesis.* 2nd ed. London, UK: Edward Arnold, 1995. pp. 41-68.

Haller, D.L., and Miles, D.R. Psychopathology is associated with completion of residential treatment in drug dependent women. *Jour­ nal of Addictive Diseases* 23(1):17-28, 2004.

Haller, D.L., Miles, **D.R.,** and Dawson, K.S. Psychopathology influences treatment reten­ tion among drug-dependent women. *Journal of Substance Abuse Treatment* 23(4):431- 436, 2002.

Hamajima, N., Hirose, K., Tajima, K., Rohan, T., Calle, E.E., Heath, C.W., et al. Alcohol, tobacco and breast cancer: Collaborative reanalysis of individual data from 53 epide­ miological studies, including 58,515 women with breast cancer and 95,067 women with­ out the disease. *British Journal of Cancer* 87(11):1234-1245, 2002.

Handmaker, N.S., and Wilbourne, P. Moti­ vational interventions in prenatal clinics. *Alcohol Research and Health* 25(3):219-229, 2001.

Hankin, **J.,** McCaul, M.E., and Heussner, **J.** Pregnant, alcohol-abusing women. *Alcohol­ ism: Clinical and Experimental Research* 24(8):1276-1286, 2000.

Hanlon, J.T., Fillenbaum, G.G., Ruby, C.M., Gray, S., and Bohannon, A. Epidemiology of over-the-counter drug use in community dwelling elderly: United States perspective. *Drugs and Aging* 18(2):123-131, 2001.

Hanna, E., Dufour, M.C., Elliott, S., and Stin­ son, F. Dying to be equal: Women, alcohol, and cardiovascular disease. *British Journal of Addiction* 87(11):1593-1597, 1992.

Harned, M.S., Najavits, L.M., and Weiss, R.D. Self-harm and suicidal behavior in women with comorbid PTSD and substance de­ pendence. *American Journal of Addiction* 15(5):392-395, 2006.

Harris, B., Lovett, L., Newcombe, **R.G.,** Read, G.F., Walker, R., and Riad-Fahmy, D. Ma­ ternity blues and major endocrine changes: Cardiff puerperal mood and hormone study

II. *British Medical Journal* 308(6934):949-

953, 1994.

Harris, M. Modifications in service delivery and clinical treatment for women diagnosed with severe mental illness who are also the survivors of sexual abuse trauma. *Journal of Mental Health Administration* 21(4):397- 406, 1994.

Harris, M., and Community Connections Trauma Work Group. *Trauma Recovery and Empowerment: A Clinician's Guidefor Working with Women in Groups.* New York: Simon & Schuster, 1998.

Harris, M., and Fallot, R.D. Designing trauma­ informed addictions services. In: Harris, M., and Fallot, **R.D.,** eds. *Using Trauma Theory to Design Service Systems.* New Directions for Mental Health Services, No. 89. San Francisco: Jossey-Bass, 2001a. pp. 57-73.

Harris, M., and Fallot, R.D. Envisioning a trauma-informed service system: A vital paradigm shift. In: Harris, M., and Fallot, R.D., eds. *Using Trauma Theory to Design Service Systems.* New Directions for Men­ tal Health Services, No. 89. San Francisco: Jossey-Bass, 2001b. pp. 3-22.

Harrison, P.M., and Beck, A.J. Prisoners in 2001. *Bureau of Justice Statistics Bulletin* Washington, DC: Bureau of Justice Statis­ tics, 2002.

Harrison, P.M., and Karberg, J.C. *Prison and Jail Inmates at Midyear 2002.* Washington, DC: Bureau of Justice Statistics, 2003.

Haskett, M.E., Miller, J.W., Whitworth, J.M., and Huffman, J.M. Intervention with co­ caine-abusing mothers. *Families in Society* 73(8):451-461, 1992.

Haswell, D.E., and Graham, M. Self-inflicted injuries: Challenging knowledge, skill, and compassion. *Canadian Family Physician* 42:1756-1758, 1761-1764, 1996.

Havens, J.R., Cornelius, L.J., Ricketts, E.P., Latkin, C.A., Bishai, D., Lloyd, J.J., Huett­ ner, S., and Strathdee, S.A. The effect of a case management intervention on drug treat­ ment entry among treatment-seeking injec­ tion drug users with and without comorbid antisocial personality disorder. *Journal of Urban Health* 84(2):267-271, 2007.

Hawke, J.M., Jainchill, N., and De Leon,

G. The prevalence of sexual abuse and its impact on the onset of drug use among

adolescents in therapeutic community drug treatment. *Journal of Child* & *Adolescent Substance Abuse* 9(3):35-49, 2000.

Heath, A.C., Slutske, W.S., and Madden,

P.A.F. Gender differences in the genetic con­ tribution to alcoholism risk and to alcohol consumption patterns. In: Wilsnack, R.W., and Wilsnack, S.C., eds. *Gender and Alco­ hol: Individual and Social Perspectives.* New Brunswick, NJ: Rutgers Center of Alcohol Studies, 1997. pp. 114-149.

Heffernan, K. The nature and predictors of substance use among lesbians. *Addictive Behaviors* 23(4):517-528, 1998.

Heflin, C.M. *Dynamics of Material Hardship in the Women's Employment Survey.* Paper pre­ sented at the annual meeting of the American Sociological Association, Montreal Conven­ tion Center, Montreal, Quebec, Canada, 2006.

Heintges, T., and Wands, **J.R.** Hepatitis C vi­ rus: epidemiology and transmission. *Hepa­ tology* 26(3):521-526, 1997.

Henderson, D.J. Drug abuse and incarcerated women: A research review. *Journal of Sub­ stance Abuse Treatment* 15(6):579-587, 1998.

Henderson, D.J., Boyd, C., and Mieczkowski,

T. Gender, relationships, and crack cocaine: A content analysis. *Research in Nursing and Health* 17(4):265-272, 1994.

Herman, **J.L.** *Trauma and Recovery.* Rev. ed.

New York: Basic Books, 1997.

Hernandez-Avila, C.A., Rounsaville, B.J., and Kranzler, H.R. Opioid-, cannabis- and alcohol-dependent women show more rapid progression to substance abuse treatment. *Drug and Alcohol Dependence* 74(3):265- 272, 2004.

Herzog, D.B., Franko, D.L., Dorer, D.J., Keel, P.K., Jackson, S., and Manzo, M.P. Drug abuse in women with eating disorders. *International Journal of Eating Disorders* 39(5):364-368, 2006.

Hewitt, P.L., and Norton, G.R. The Beck Anxi­ ety Inventory: A psychometric analysis. *Psy­ chological Assessment* 5(4):408-412, 1993.

Hiebert-Murphy, D., and Woytkiw, L. A model for working with women dealing with child sexual abuse and addictions: The Laurel Centre, Winnipeg, Manitoba, Canada. *Jour­ nal of Substance Abuse Treatment* 18(4):387- 394, 2000.

Hien, D.A., Cohen, L.R., Miele, G.M., Litt, L.C., and Capstick, C. Promising treatments for women with comorbid PTSD and sub­ stance use disorders. *American Journal of Psychiatry* 161(8):1426-1432, 2004.

Highleyman, L. Women and HCV. *HCV Advo­ cate* San Francisco, CA: Hepatitis C Support Project 2005.

**Hill, R.B.** *The Strengths of Black Families.* New York: Emerson Hall Publishers, 1972.

Hillhouse, M.P., and Fiorentine, R. 12-Step program participation and effectiveness: Do gender and ethnic differences exist? *Journal of Drug Issues* 31(3):767-780, 2001.

Hoek, H. The distribution of eating disorders. In: Brownell, K.D., and Fairburn, C.G., eds. *Eating Disorders and Obesity: A Com­ prehensive Handbook.* New York: Guilford Press, 1995. pp. 207-211.

Hoek, H.W., and van Hoeken, D. Review of the prevalence and incidence of eating disorders. *International Journal of Eating Disorders* 34(4):383-396, 2003.

Hoffman, E.H., Blackburn, C., and Cullari, S. Brief residential treatment for nicotine ad­ diction: a five-year follow-up study. *Psycho­ logical Reports* 89(1):99-105, 2001.

Hofmann, S.G., and Smits, J.A. Cognitive-be­ havioral therapy for adult anxiety disorders: a meta-analysis of randomized placebo-con­ trolled trials. *Journal of Clinical Psychiatry* 69(4):621-632, 2008.

Holcomb-McCoy, C. Group mentoring with ur­ ban African American female adolescents. *E­ Journal of Teaching and Learning in Diverse Settings* 2(1):161-176. Baton Rouge, **LA:** Southern University and A&M College 2004.

Holdcraft, L.C., and Comtois, K.A. Description of and preliminary data from a women's dual diagnosis community mental health program. *Canadian Journal of Community Mental Health* 21(2):91-109, 2002.

Holderness, C.C., Brooks-Gunn, J., and War­ ren, M.P. Co-morbidity of eating disorders and substance abuse: Review of the litera­ ture. *International Journal of Eating Disor­ ders* 16(1):1-34, 1994.

Holman, C.D.J., English, D.R., Milne, E., and Winter, M.G. Meta-analysis of alcohol and all-cause mortality: A validation of NHMRC recommendations. *Medical Journal of Aus­ tralia* 164(3):141-145, 1996.

Hommer, D., Momenan, R., Rawlings, R., Ra­ gan, P., Williams, W., Rio, D., and Eckardt,

M. Decreased corpus callosum size among alcoholic women. *Archives of Neurology* 53(4):359-363, 1996.

Hommer, D.W., Momenan, R., Kaiser, E., and Rawlings, R.R. Evidence for a gender-re­ lated effect of alcoholism on brain volumes. *American Journal of Psychiatry* 158(2):198- 204, 2001.

Hope, S., Rodgers, B., and Power, C. Marital status transitions and psychological dis­ tress: Longitudinal evidence from a national population sample. *Psychological Medicine* 29(2):381-389, 1999.

Horrell, S.C.V. Effectiveness of cognitive-be­ havioral therapy with adult ethnic minority clients: A review. *Professional Psychology: Research and Practice* 39(2):160-168, 2008.

Horwitz, A.V., White, H.R., and Howell-White,

S. The use of multiple outcomes in stress re­ search: A case study of gender differences in responses to marital dissolution. *Journal of Health and Social Behavior* 37(3):278-291, 1996.

Howell, E.M., and Chasnoff, I.J. Perinatal sub­ stance abuse treatment: Findings from focus groups with clients and providers. *Journal*

*of Substance Abuse Treatment* 17(1-2):139- 148, 1999.

Howland, R.H. The treatment of persons with dual diagnoses in a rural community. *Psychi­ atric Quarterly* 66(1):33-49, 1995.

Hser, Y.I., Anglin, M.D., and Booth, M.W. Sex differences in addict careers: 3. Addic­

tion. *American Journal of Drug and Alcohol Abuse* 13(3):231-251, 1987.

Hser, Y.I., Evans, E., Huang, D., and Anglin,

D.M. Relationship between drug treatment services, retention, and outcomes. *Psychiat­ ric Services* 55(7):767-774, 2004.

Hser, Y.I., Polinsky, M.L., Maglione, M., and Anglin, M.D. Matching clients' needs with drug treatment services. *Journal of Sub­ stance Abuse Treatment* 16(4):299-305, 1999.

Hudson, J.I., Hiripi, E., Pope, H.G., Jr., and Kessler, R.C. The prevalence and correlates of eating disorders in the National Comorbid­ ity Survey Replication. *Biological Psychiatry* 61(3):348-358, 2007.

Hudson, J.I., Weiss, R.D., Pope, H.G., Jr., McElroy, S.K., and Mirin, S.M. Eating disorders **in** hospitalized substance abus­ ers. *American Journal of Drug and Alcohol Abuse* 18(1):75-85, 1992.

Hughes, **P.H.,** Coletti, S.D., Neri, R.L., Ur­

mann, C.F., Stahl, S., Sicilian, **D.M.,** and Anthony, J.C. Retaining cocaine-abusing women in a therapeutic community: The effect of a child live-in program. *American Journal of Public Health* 85(8 Pt 1):1149- 1152, 1995.

Hughes, T.L., and Eliason, M. Substance use and abuse in lesbian, gay, bisexual and transgender populations. *Journal of Prima­ ry Prevention* 22(3):263-298, 2002.

Hughes, T.L., and Jacobson, **K.M.** Sexual orientation and women's smoking. *Current Womens Health Report* 3(3):254-261, 2003.

Hughes, T.L., and Norris, J. Sexuality, sexual orientation, and violence: Pieces in the puzzle of women's use and abuse of alcohol. In: McElmurry, F.J., and Parker, R.S.,

eds. *Annual Review of Womens Health: Vol.*

*II.* New York: National League for Nursing Press, 1995. pp. 285-317.

Hughes, T.L., and Wilsnack, S.C. Use of alcohol among lesbians: Research and clinical impli­ cations. *American Journal of Orthopsychia­ try* 67(1):20-36, 1997.

Hughes, T.L., Haas, A.P., Razzano, L., Cassidy, R., and Matthews, A. Comparing lesbians' and heterosexual women's mental health: Findings from a multi-site study.

*Journal of Gay and Lesbian Social Services*

11(1):57-76, 2000.

Hughes, T.L., Johnson, T.P., Wilsnack, S.C., and Szalacha, L.A. Childhood risk factors for alcohol abuse and psychological distress among adult lesbians. *Child Abuse and Ne­ glect* 31(7):769-789, 2007.

Appendix A: Bibliography 231

Hurd, Y.L., Wang, X., Anderson, V., Beck, 0., Minkoff, H., and Dow-Edwards, D. Marijua­ na impairs growth in mid-gestation fetuses.

*Neurotoxicology and Teratology* 27(2):221- 229, 2005.

Hurt, H., Brodsky, N.L., Betancourt, L., Brait­ man, L.E., Malmud, E., and Giannetta,

J. Cocaine-exposed children: Follow-up through 30 months. *Journal of Developmen­ tal and Behavioral Pediatrics* 16(1):29-35, 1995.

Hurt, H., Malmud, E., Betancourt, L.M., Brod­ sky, N.L., and Giannetta, J.M. A prospective comparison of developmental outcome of children with in utero cocaine exposure and controls using the Battelle Developmental Inventory. *Journal of Developmental and Behavioral Pediatrics* 22(1):27-34, 2001.

Hussong, R.G., Bird, K., and Murphy, C.V. Substance abuse among American Indian women of childbearing age. *IRS Primary Care Provider* 19(12):196-199, 1994.

Hyman, S.M., Paliwal, P., and Sinha, R. Child­ hood maltreatment, perceived stress, and stress-related coping in recently abstinent cocaine dependent adults. *Psychology of Ad­ dictive Behaviors* 21(2):233-238, 2007.

Hyman, S.M., Paliwal, P., Chaplin, T.M., Mazure, C.M., Rounsaville, **B.J.,** and Sinha,

**R.** Severity of childhood trauma is predic­ tive of cocaine relapse outcomes in women but not men. *Drug and Alcohol Dependence* 92(1-3):208-216, 2008.

Hymbaugh, K., Miller, L.A., Druschel, C.M., Podvin, D.W., Meaney, F.J., and Boyle,

C.A. A multiple source methodology for the surveillance of fetal alcohol syndrome--The Fetal Alcohol Syndrome Surveillance Net­ work (FASSNet). *Teratology* 66 Suppl l:S41- S49, 2002.

Indian Health Service. Demographic statistics section of regional differences in Indian health 2000-2001: Tables only. Rockville, MD: Indian Health Service, 2002.

International Longevity Center-USA. Caregiving in America. New York, NY: 2006.

Jacobson, J.O., Robinson, P.L., and Bluthen­ thal, **R.N.** Racial disparities in completion rates from publicly funded alcohol treat­ ment: economic resources explain more than demographics and addiction severity. *Health Services Research* 42(2):773-794, 2007.

Janes, J. Their own worst enemy? Management and prevention of self-harm. *Professional Nurse* 9(12):838-841, 1994.

Janoff-Bulman, R. *Shattered Assumptions: Towards a New Psychology of Trauma.* New York: Free Press, 1992.

Jansson, **L.M.,** Svikis, D.S., Breon, D., and Cieslak, **R.** Intensity of Case Management Services: Does More Equal Better for Drug­ Dependent Women and Their Children? *So­ cial Work in Mental Health* 3(4):63-78, 2005.

Jarvis, M.A., and Schnoll, S.H. Methadone use during pregnancy. In: Chiang, C.N., and Finnegan, L.P., eds. *Medications Develop­ ment for the Treatment of Pregnant Addicts and Their Infants.* **NIDA** Research Mono­ graph 149. NIH Publication No. 95-3891.

Rockville, MD: National Institute on Drug Abuse, 1995. pp. 58-77.

Jarvis, **T.J.,** Copeland, J., and Walton, L. Exploring the nature of the relationship between child sexual abuse and substance use among women. *Addiction* 93(6):865-875, 1998.

Jennison, K.M., and Johnson, K.A. Alcohol dependence in adult children of alcoholics: Longitudinal evidence of early risk. *Journal of Drug Education* 28(1):19-37, 1998.

Jennison, K.M., and Johnson, K.A. Parental al­ coholism as a risk factor for DSM-IV defined alcohol abuse and dependence in American women: The protective benefits of dyadic cohesion in marital communication. *Ameri­ can Journal of Drug and Alcohol Abuse* 27(2):349-374, 2001.

Jessup, M. Addiction in women: Prevalence, profiles, and meaning. *Journal of Obstet­ ric, Gynecologic, and Neonatal Nursing* 26(4):449-458, 1997.

Jessup, **M., Humphreys, J., Brindis,** C., **and** Lee, **K.** Extrinsic barriers to substance abuse treatment among pregnant drug dependent women. *Journal of Drug Issues* 23(2):285- 304, 2003.

Joe, G.W., Rowan-Szal, G.A., Greener, **J.M.,** and Simpson, D.D. The TCU Brief Intake and Client Problem Index (CPI). Poster presented at the American Methadone Treat­ ment Association conference, San Francisco, April 2000.

Joe, G.W., Simpson, D.D., and Broome, K.M.

Retention and patient engagement models

for different treatment modalities in DATOS. *Drug and Alcohol Dependence* 57(2):113- 125, 1999.

Joe, G.W., Simpson, D.D., Dansereau, D.F., and Rowan-Szal, G.A. Relationships between counseling rapport and drug abuse treatment outcomes. *Psychiatric Services* 52(9):1223- 1229, 2001.

Joe, K.A. "Ice is strong enough for a man but made for a woman:" A social cultural analy­ sis of crystal methamphetamine use among Asian Pacific Americans. *Crime, Law, and Social Change* 22:269-289, 1995.

Joe, K.A. Lives and times of Asian-Pacific American women drug users: An ethno­ graphic study of their methamphetamine use. *Journal of Drug Issues* 26(1):199-218, 1996.

Joe, S., Baser, R.E., Breeden, G., Neighbors, H.W., and Jackson, J.S. Prevalence of and risk factors for lifetime suicide attempts among blacks in the United States. *JAMA* 296(17):2112-2123, 2006.

John, U., Meyer, C., Rumpf, H.J., and Hapke,

U. Psychiatric comorbidity including nico­ tine dependence among individuals with eating disorder criteria in an adult general population sample. *Psychiatry Research* 141(1):71-79, 2006.

Johnson, H.L., Glassman, M.B., Fiks, K.B., and Rosen, T.S. Path analysis of variables affecting 36-month outcome in a population of multi-risk children. *Infant Behavior and Development* 10(4):451-465, 1987.

Johnson, J.L., and Leff, M. Children of sub­ stance abusers: Overview of research find­ ings. *Pediatrics* 103(5 Pt 2):1085-1099, 1999.

Johnson, P.B., Richter, L., Kleber, H.D., McLellan, A.T., and Carise, D. Telescoping of drinking-related behaviors: Gender, ra­ cial/ethnic, and age comparisons. *Substance Use* & *Misuse* 40(8):1139-1151, 2005.

Johnson, T.P., and Hughes, **T.L.** Reliability

and concurrent validity of the cage screening questions: A Comparison oflesbians and het­ erosexual women. *Substance Use* & *Misuse* 40(5):657-669, 2005.

Jones, H.E., and Johnson, R.E. Pregnancy and substance abuse. *Current Opinion in Psy­ chiatry* 14:187-193, 2001.

Jones, H.E., Haug, N., Silverman, K., Stitzer, M., and Svikis, D. The effectiveness of incen­ tives in enhancing treatment attendance and drug abstinence in methadone-maintained pregnant women. *Drug and Alcohol Depen­ dence* 61(3):297-306, 2001.

Jones, **H. E.,** Johnson, **R.** E., Jasinski, **D.R.,**

O'Grady, K. E., Chisholm, C. A., Choo, R.

E. et al. Buprenorphine versus methadone in the treatment of pregnant opioid-dependent patients: Effects on the neonatal abstinence syndrome. *Drug and Alcohol Dependence,* 79, 2005. pp. 1-10.

Jones, K.L., and Smith, D.W. Recognition of the fetal alcohol syndrome in early infancy. *Lancet* 2(7836):999-1001, 1973.

Jones-Webb, R.J., Hsiao, C.Y., and Hannan, P. Relationships between socioeconomic status and drinking problems among black and white men. *Alcoholism: Clinical and Experi­ mental Research* 19(3):623-627, 1995.

Jonker, J., De Jong, C.A., de Weert-van Oene, G.H., and Gijs, L. Gender-role stereotypes and interpersonal behavior: How addicted inpatients view their ideal male and female therapist. *Journal of Substance Abuse Treat­ ment* 19(3):307-312, 2000.

Jordan, J.V., and Hartling, L.M. New devel­ opments in relational-cultural theory. In: Ballou, M., and Brown, L.S., eds. *Rethink­ ing Mental Health and Disorders: Feminists Perspectives.* New York: Guilford Publica­ tions, 2002. pp. 48-70.

Jordan, K.M., and Deluty, R.H. Coming out for lesbian women: Its relation to anxiety, posi­ tive affectivity, self-esteem and social sup­ port. *Journal of Homosexuality* 35(2):41-63, 1998.

Jumper Thurman, P., and Plested, B. Health needs of American Indian women. *Drug Ad­ diction Research and the Health of Women.* (eds.) Wetherington, Cora Lee and Roman, Adele B. 553-562. Bethesda, MD: National Institute on Drug Abuse, 1998.

Kail, B.L., and Elberth, M. Moving the Latina substance abuser toward treatment: The role of gender and culture. *Journal of Ethnicity in Substance Abuse* 1(3):3-16, 2002.

Kalarchian, M.A., Marcus, M.D., Levine, M.D., Courcoulas, A.P., Pilkonis, P.A., Ringham, R.M., Soulakova, J.N., Weissfeld, L.A., and Rofey, D.L. Psychiatric disorders among bariatric surgery candidates: Relationship to obesity and functional health status. *Ameri­ can Jozirnal of Psychiatry* 164(2):328-334, 2007.

Kaltenbach, K. The effects of maternal cocaine abuse on mothers and newborns. *Current Psychiatry Reports* 2(6):514-518, 2000.

Kaltenbach, K., Berghella, **V., and** Finnegan,

L. Opioid dependence during pregnancy: Effects and management. *Obstetrics and Gynecology* 25(1):139-151, 1998.

Kaltenbach, K.A. Effects of in-utero opiate exposure: New paradigms for old questions. *Drug and Alcohol Dependence* 36(2):83-87, 1994.

Kaltenbach, K.A. Exposure to opiates: Behav­ ioral outcomes in preschool and school-age children. In: Wetherington, C.L., Smeriglio, V.L., and Finnegan, L.P., eds. *Behavioral Studies of Drug-Exposed Offspring: Meth­ odological Issues in Human and Animal Research.* NIDA Research Monograph 164. NIH Publication No. 96-4105. Rockville, MD: National Institute on Drug Abuse, 1996. pp. 230-241.

Kamimori, G.H., Sirisuth, N., Greenblatt, D.J., and Eddington, N.D. The influence of the menstrual cycle on triazolam and indo­ cyanine green pharmacokinetics. *Journal of Clinical Pharmacology* 40(7):739-744, 2000.

Karberg, J.C., and James, D.J. Substance Dependence, Abuse, and Treatment of Jail Inmates, 2002. *Bureau of Justice Statistics: Special Report* JulyNCJ209588 Washington, DC: U.S. Department of Justice, 2005.

Karenga, M. *Kwanzaa; A Celebration of Fam­ ily, Community, and Culture.* Los Angeles: University of Sankore Press, 1998.

Kaskutas, L.A., Zhang, L., French, M.T., and Witbrodt, J. Women's programs versus mixed-gender day treatment: Results from a randomized study. *Addiction* 100(1):60-69, 2005.

Kasi, C.D. *Many Roads, One Journey: Moving Beyond the Twelve Steps.* New York: Harper Perennial, 1992.

Katz, E.C., Chutuape, M.A., Jones, H., Ja­ sinski, D., Fingerhood, M., and Stitzer, M. Abstinence incentive effects in a short-term outpatient detoxification program. *Experi­ mental and Clinical Psychopharmacology* 12(4):262-268, 2004.

Kauffman, E., Dore, **M.M.,** and Nelson-Zlupko,

L. The role of women's therapy groups in the treatment of chemical dependence. *American Journal of Orthopsychiatry* 65(3):355-363, 1995.

Kayemba-Kay's, S., and Laclyde, **J.P. Bu­** prenorphine withdrawal syndrome in newborns: a report of 13 cases. *Addiction* 98(11):1599-1604, 2003.

Kaysen, D., Dillworth, T.M., Simpson, T., Wal­ drop, A., Larimer, M.E., and Resick, P.A. Domestic violence and alcohol use: Trauma­ related symptoms and motives for drinking. *Addictive Behaviors* 32(6):1272-1283, 2007.

Keefe, S.E., and Padilla, A.M. *Chicano Ethnic­ ity.* Albuquerque, NM: University of New Mexico Press, 1987.

Kelly, B.C., and Parsons, J.T. Prescription drug misuse among club drug-using young adults. *American Journal of Drug and Alco­ hol Abuse* 33(6):875-884, 2007.

Kelly, **P.J.,** Blacksin, B., and Mason, E. Factors affecting substance abuse treatment comple­ tion for women. *Issues in Mental Health Nursing* 22(3):287-304, 2001a.

Kelly, R., Zatzick, D., and Anders, T. The detection and treatment of psychiatric dis­ orders and substance use among pregnant women cared for in obstetrics. *American Journal of Psychiatry* 158(2):213-219, 2001b.

Kelly, S. Cognitive-behavioral therapy with African Americans. In: Hays, P.A., and lwamasa, **G.Y.,** eds. *Culturally Responsive Cognitive-Behavioral Therapy: Assessment, Practice, and Supervision.* Washington, DC: American Psychological Association, 2006. pp. 97-116.

Kendler, K.S., and Prescott, C.A. Cannabis use, abuse, and dependence in a population­ based sample of female twins. *American Journal of Psychiatry* 155(8):1016-1022, 1998.

Kendler, K.S., Bulik, C.M., Silberg, J., Het­ tema, J.M., Myers, J., and Prescott, C.A. Childhood sexual abuse and adult psychiat­ ric and substance use disorders in women: An epidemiological and co twin control analysis. *Archives of General Psychiatry* 57(10):953-959, 2000.

Kendler, K.S., Gardner, C.O., and Prescott,

C.A. Religion, psychopathology, and sub­ stance use and abuse; A multimeasure, genet­ ic-epidemiologic study. *American Journal of Psychiatry* 154(3):322-329, 1997.

Kendler, K.S., Heath, A.C., Neale, M.C., Kes­ sler, R.C., and Eaves, **L.J.** A population­ based twin study of alcoholism in women.

*JAMA* 268(14):1877-1882, 1992.

Kendler, K.S., Liu, X.Q., Gardner, C.O., Mc­ Cullough, M.E., Larson, D., and Prescott,

C.A. Dimensions of religiosity and their rela­ tionship to lifetime psychiatric and substance use disorders. *American Journal of Psychia­ try* 160(3):496-503, 2003.

Kendler, K.S., Thornton, L.M., and Prescott, C.A. Gender differences in the rates of expo­ sure to stressful life events and sensitivity to their depressogenic effects. *American Jour­ nal of Psychiatry* 158(4):587-593, 2001.

Kennedy, C., Finkelstein, N., Hutchins, E., and Mahoney, J. Improving screening for alcohol use during pregnancy: the Massachusetts ASAP program. *Maternal* & *Child Health Journal* 8(3):137-147, 2004.

Kesmodel, U., Wisborg, K., Olsen, S.F., Hen­ riksen, T.B., and Seeber, N.J. Moderate alcohol intake during pregnancy and the risk of stillbirth and death in the first year of life. *American Journal of Epidemiology* 155(4):305-312, 2002.

Kessler, R.C., Borges, G., and Walters, E.E. Prevalence of and risk factors for lifetime suicide attempts in the National Comorbid­ ity Survey. *Archives of General Psychiatry* 56(7):617-626, 1999.

Kessler, R.C., Crum, R.M., Warner, L.A., Nelson, C.B., Schulenberg, J., and Anthony,

J.C. Lifetime co-occurrence of DSM-111-R alcohol abuse and dependence with other psychiatric disorders in the National Comor­ bidity Survey. *Archives of General Psychia­ try* 54(4):313-321, 1997a.

Kessler, R.C., McGonagle, K.A., Zhao, S., Nel­ son, C.B., Hughes, M., Eshleman, S., Wit­ tchen, H.U., and Kendler, K.S. Lifetime and 12-month prevalence of DSM-111-R psychiat­ ric disorders in the United States. *Archives of General Psychiatry* 51(1):8-19, 1994.

Kessler, R.C., Sonnega, A., Bromet, E., Hughes, M., and Nelson, C.B. Posttraumatic stress disorder in the National Comorbid-

ity Survey. *Archives of General Psychiatry*

52(12):1048-1060, 1995.

Kessler, R.C., Zhao, S., Blazer, D.G., and Swartz, M. Prevalence, correlates, and course of minor depression and major de­ pression in the national comorbidity survey. *Journal of Affective Disorders* 45(1-2):19-30, 1997b.

Key, J., Hodgson, S., Omar, R.Z., Jensen,

T.K., Thompson, S.G., Boobis, A.R., Da­ vies, D.S., and Elliott, P. Meta-analysis of studies of alcohol and breast cancer with consideration of the methodological issues. *Cancer Causes and Control* 17(6):759-770, 2006.

Killeen, T., Hien, D., Campbell, A., Brown, C., Hansen, C., Jiang, **H.,** Kristman-Valente, A., Neuenfeldt, C., Rocz-de la, **L.N.,** Samp­ son, **R.,** Suarez-Morales, **L.,** Wells, E., Brigham, G., and Nunes, E. Adverse events in an integrated trauma-focused interven­ tion for women in community substance abuse treatment. *Journal of Substance Abuse Treatment,* 2008.

Kilpatrick, D.G., Acierno, **R.,** Resnick, H.S., Saunders, B.E., and Best, C.L. A 2-year longitudinal analysis of the relationships between violent assault and substance use in women. *Journal of Consulting and Clinical Psychology* 65(5):834-847, 1997.

Kitano, **K.J.,** and Louie, L.J. Asian and Pacific Islander women and addiction. In: Strauss­ ner, S.L.A., and Brown, S., eds. *The Hand­ book Of Addiction Treatment For Women: Theory And Practice.* San Francisco: Jossey­ Bass, 2002. pp. 348-373.

Klein, H., Elifson, K.W., and Sterk, C.E. Per­ ceived temptation to use drugs and actual drug use among women. *Journal of Drug Issues* 33(1):161-192, 2003.

Kleiner, K.D., Gold, M.S., Frost-Pineda,

K., Lenz-Brunsman, B., Perri, M.G., and Jacobs, W.S. Body Mass Index and Al­ cohol Use. *Journal of Addictive Diseases* 23(3):105-118, 2004.

Klitzner, M., Fisher, D., Stewart, K., and Gil­ bert, S. *Substance Abuse: Early Intervention for Adolescents.* Princeton, NJ: The Robert Wood Johnson Foundation, 1992.

Knight, **D.K.,** and Simpson, **D.D.** Influences of family and friends on client progress during drug abuse treatment. *Journal of Substance Abuse* 8(4):417-429, 1996.

Knight, D.K., Logan, S., and Simpson, D.D. Predictors of program completion for women in residential substance abuse treatment.

*American Journal of Drug and Alcohol Abuse* 27(1):1-18, 2001a.

Knight, D.K., Wallace, G.L., Joe, G.W., and Logan, S.M. Change in psychosocial func­ tioning and social relations among women in residential substance abuse treatment. *Journal of Substance Abuse* 13(4):533-547, 2001b.

Knight, K. TCU Drug Screen II. Fort Worth, **TX:** Texas Christian University, Institute of Behavioral Research, 2002.

Knight, K., Simpson, D.D., and Hiller, M.L. Screening and referral for substance abuse treatment in the criminal justice system. In: Leukefeld, C.G., Tims, **F.M.,** and Farabee, **D.,** eds. *Treatment of Dmg Offenders: Poli­ cies and Issues.* New York: Springer Publish­ ing Company, 2002. pp. 259-272.

Koegel, **P.,** Sullivan, G., Burnam, A., Morton, S.C., and Wenzel, S. Utilization of mental health and substance abuse services among homeless adults **in** Los Angeles. *Medical Care* 37(3):306-317, 1999.

Koh, A.S. Use of preventive health behaviors by lesbian, bisexual, and heterosexual women: Questionnaire survey. *Western Journal of Medicine* 172(6):379-384, 2000.

Kohn, L.P., Oden, T., Munoz, R.F., Robinson, A., and Leavitt, D. Adapted cognitive be­ havioral group therapy for depressed low-in­ come African American women. *Community Mental Health Journal* 38(6):497-504, 2002.

Kornstein, S.G., Schatzberg, A.F., Thase, M.E., Yonkers, K.A., McCullough, J.P.,

Keitner, G.I., Gelenberg, A.J., Ryan, C.E.,

Hess, A.L., Harrison, W., Davis, S.M., and Keller, **M.B.** Gender differences in chronic major and double depression. *Journal of Af­ fective Disorders* 60(1):1-11, 2000.

Kovalesky, A. Factors affecting mother-child visiting identified by women with histories of substance abuse and child custody loss. *Child Welfare* 80(6):749-768, 2001.

Kreek, M.J. Opiate-ethanol interactions: Impli­ cations for the biological basis and treatment of combined addictive diseases. In: Harris, L.S., ed. *Problems of Drug Dependence, 1987: Proceedings of the 49th Annual Sci­ entific Meeting, the Committee on Problems of Drug Dependence, Inc.* **NIDA** Research Monograph Series 81. Rockville, MD: Na­ tional Institute on Drug Abuse, 1988. pp.

428-439.

Krieger, N. Embodying inequality: A review of concepts, measures, and methods for study­ ing health consequences of discrimination. *International Journal of Health Services* 29(2):295-352, 1999.

Kuba, S.A., and Hanchey, S.G. Reclaiming women's bodies: A feminist perspective on eating disorders. In: Van Den Bergh, N., ed. *Feminist Perspectives on Addictions.* New York: Springer Publishing, 1991. pp. 125-137.

Kuehn, **B.M.** Despite benefit, physicians slow to offer brief advice on harmful alcohol use. *JAMA* 299(7):751-753, 2008.

Kumar, C., Mcivor, R.J., Davies, T., Brown, N., Papadopoulos, A., Wieck, A., Check­ ley, S.A., Campbell, I.C., and Marks, **M.N.** Estrogen administration does not reduce the rate of recurrence of affective psychosis after childbirth. *Jozirnal of Clinical Psychiatry* 64(2):112-118, 2003.

Kurdek, L.A., and Schmitt, **J.P.** Relationship quality of partners in heterosexual married, heterosexual cohabiting, and gay and lesbian relationships. *Journal of Personality and Social Psychology* 51(4):711-720, 1986.

Kuyken, W., Dalgleish, T., and Holden, E.R. Advances in cognitive-behavioural therapy for unipolar depression. *The Canadian Journal of Psychiatry I La Revue Cana­ dienne De Psychiatrie* 52(1):5-13, 2007.

LaFromboise, T.D., Trimble, J.E., andMohatt,

G.V. Counseling intervention and American Indian tradition: An integrative approach. In: Atkinson, D.R., and Morten, G., eds. *Counseling American minorities.* 5th ed. New York: McGraw-Hill, 1998. pp. 159-182.

Lai, S., Lai, H., Page, J.B., and McCoy, C.B. The association between cigarette smoking and drug abuse in the United States. *Journal of Addictive Diseases* 19(4):11-24, 2000.

Lando, H.A., Pirie, P.L., Hellerstedt, W.L., and McGovern, P.G. Survey of smoking patterns, attitudes, and interest in quitting. *American Journal of Preventive Medicine* 7(1):18-23, 1991.

Larson, M.J., Miller, L., Becker, M., Richard­ son, E., Kammerer, N., Thom, J., Gampel, J., and Savage, A. Physical health burdens of women with trauma histories and co-oc­ curring substance abuse and mental disor­ ders. *Journal of Behavior Health Services* & *Research* 32(2):128-140, 2005.

Larsson, S.C., Giovannucci, E., and Wolk, A. Alcoholic beverage consumption and gastric cancer risk: A prospective population-based study in women. *International Journal of Cancer* 120(2):373-377, 2007.

Laudet, A., Magura, S., Furst, R.T., Kumar, N., and Whitney, S. Male partners of sub­ stance-abusing women in treatment: An ex­ ploratory study. *American Journal of Drug and Alcohol Abuse* 25(4):607-627, 1999.

Laumann, E.O., Gagnon, **J.H.,** Michael, R.T., and Michaels, S. *The social organization*

*of sexuality: Sexual practices in the United States.* Chicago: University of Chicago Press, 1994.

Leech, S.L., Richardson, G.A., Goldschmidt, L., and Day, N.L. Prenatal substance expo­ sure: Effects on attention and impulsivity of 6-year-olds. *Neurotoxicology and Teratology* 21(2):109-118, 1999.

Legal Action Center. *Steps to Success: Helping Women with Alcohol and Drug Problems Movefrom Welfare to Work.* Washington, DC: Legal Action Center, 1999.

Lehmann, E.R., Kass, P.H., Drake, C.M., and Nichols, S.B. Risk factors for first-time homelessness in low-income women. *Ameri­*

*can Journal of Orthopsychiatry* 77(1):20-28, 2007.

Leigh, W.A. Women of color health data book: Adolescents to seniors. (3rd): Bethesda, MD: Office of Research on Women's Health, Office of the Director, National Institutes of Health 2006.

Lenz, S.K., Goldberg, M.S., Labreche, F., Parent, M.E., and Valois, M.F. Association between alcohol consumption and postmeno­ pausal breast cancer: Results of a case­ control study in Montreal, Quebec, Canada. *Cancer Causes and Control* 13(8):701-710, 2002.

Leong, F.T., and Lee, S.H. A cultural accommo­ dation model for cross-cultural psychothera­ py: Illustrated with the case of Asian Ameri­ cans. *Psychotherapy: Theory, Research, Practice, Training* 43(4):410-423, 2006.

Leong, F.T.L. Cultural accommodation as method and metaphor. *American Psycholo­ gist* 62(8):916-927, 2007.

Leong, F.T.L., Leach, **M.M.,** Yeh, C., and Chou, E. Suicide among Asian Americans: What do we know? What do we need to know? *Death Studies* 31(5):417-434, 2007.

Leong, P. Religion, flesh, and blood: Re-creating religious culture in the context of HIV/AIDS. *Sociology of Religion: A Quarterly Review* 67(3): 2006.

Leserman, J. Sexual Abuse History: Prevalence, Health Effects, Mediators, and Psycho­ logical Treatment. *Psychosomatic Medicine* 67(6):906-915, 2005.

Lessler, J.T., and O'Reilly, J.M. Mode of inter­ view and reporting of sensitive issues: Design and implementation of audio computer­ assisted self-interviewing. In: Harrison, L., and Hughes, A., eds. *The Validity of Self­ Reported Drug Use: Improving the Accuracy of Survey Estimates.* NIDA Research Mono­ graph 167. Rockville, MD: National Institute on Drug Abuse, 1997. pp. 366-382.

Leukefeld, C., Godlaski, T., Clark, **J.,** Brown, C., and Hays, L. *Behavioral Therapy for Rural Substance Abusers: A Treatment In­ tervention for Substance Abusers.* Lexington, KY: University Press of Kentucky, 2000.

Levin, R., McKean, L., and Raphael, J. Path­ ways to and from homelessness: Women and children in Chicago shelters. Chicago: Center for Impact Research 2004.

Levine, **M.D.,** and Marcus, M.D. Do changes in mood and concerns about weight relate to smoking relapse in the postpartum pe­ riod? *Archives of Womens Mental Health* 7(3):155-166, 2004.

Lewis, L.M. Culturally appropriate substance abuse treatment for parenting African American women. *Issues in Mental Health Nursing* 25(5):451-472, *2004a.*

Lewis, M.W., Misra, S., Johnson, **H.L.,** and Rosen, T.S. Neurological and developmen­ tal outcomes of prenatally cocaine-exposed offspring from 12 to 36 months. *American Journal of Drug* & *Alcohol Abuse* 30(2):299- 320, *2004b.*

Lewis, R.A., Haller, D.L., Branch, D., and Ingersoll, K.S. Retention issues involving drug-abusing women in treatment research. In: Rahdert, E.R., ed. *Treatment for Drug­ Exposed Women and Their Children: Ad­ vances in Research Methodology.* NIDA Re­ search Monograph 166. NIH Publication No. 96-3632. Rockville, MD: National Institute on Drug Abuse, 1996. pp. 110-122.

Lex, **B.** Gender differences **and** substance abuse. *Advances in Substance Abuse* 4:225- 296, 1991.

Lex, B.W. Alcohol and other psychoactive sub­ stance dependence in women and men. In: Seeman, M.V., ed. *Gender and Psychopa­ thology.* Washington, DC: American Psychi­ atric Press, 1995. pp. 311-358.

Lex, B.W., Mendelson, **J.H.,** Bavli, S., Harvey, K., and Mello, N.K. Effects of acute mari­ juana smoking on pulse rate and mood states in women. *Psychopharmacology (Berl)* 84(2):178-187, 1984.

Li, C.I., Malone, K.E., Porter, P.L., Weiss,

N.S., Tang, M.T., and Daling, J.R. The relationship between alcohol use and risk of breast cancer by histology and hormone receptor status among women 65-79 years of age. *Cancer Epidemiology Biomarkers Prevention* 12(10):1061-1066, 2003.

Li, L., and Ford, J.A. Illicit drug use by women with disabilities. *American Journal of Drug and Alcohol Abuse* 24(3):405-418, 1998.

Lieber, C. S. (2000). Ethnic and gender differ­ ences in ethanol metabolism. *Alcoholism: Clinical* & *Experimental Research* 24, 417-

418.

Liechti, M.E., Gamma, A., and Vollenweider,

**F.X.** Gender differences in the subjective effects of MDMA. *Psychopharmacology* 154(2):161-168, 2001.

Liepman, M., Goldman, R., Monroe, A., Green, K., Sattler, A., Broadhurst, J., and Gomberg, E. Substance abuse by special populations of women. In: Gomberg, E., and Nirenberg, T., eds. *Women and Substance Abuse.* Norwood, NJ: Ablex Press, 1993.

Lifschitz, M.H., Wilson, G.S., Smith, E.O., and Desmond, M.M. Factors affecting head growth and intellectual function in children of drug addicts. *Pediatrics* 75(2):269-274, 1985.

Lincoln, A.K., Liebschutz, J.M., Chernoff, M., Nguyen, D., and Amaro, **H.** Brief screening for co-occurring disorders among women en­ tering substance abuse treatment. *Substance Abuse Treatment, Prevention and Policy* 1:26, 2006.

Longshore, D., Grills, C., Annon, K., and Grady, R. Promoting recovery from drug abuse: An Afrocentric intervention. *Journal of Black Studies* 28(3):319-332, 1998.

Longshore, D., Hsieh, S.C., Anglin, M.D., and Annon, T.A. Ethnic patterns in drug abuse treatment utilization. *Journal of Mental Health Administration* 19(3):268-277, 1992.

Lopez, F. *Confidentiality of Patient Records for Alcohol and Other Drug Treatment.* Techni­ cal Assistance Publication Series 13. HHS Publication No. (SMA) 99-3321. Rockville, MD: Center for Substance Abuse Treatment, 1994.

Loring, M., and Powell, B. Gender, race, and **DSM-III:** A study of the objectivity of psychi­ atric diagnostic behavior. *Journal of Health and Social Behavior* 29(1):1-22, 1988.

Louisiana Department of **Health** and Hospitals. News Release: New Screening Project Assists Pregnant Women Seeking to Quit Using Al­ cohol, Tobacco, Other Drugs. Baton Rouge, LA, 2007.

Lucas, G.M., Griswold, M., Gebo, K.A., Keru­ ly, **J.,** Chaisson, R.E., and Moore, **R.D.** Illic­ it drug use and HIV-1 disease progression: a longitudinal study in the era of highly active antiretroviral therapy. *American Journal of Epidemiology* 163(5):412-420, 2006.

Lundgren, L.M., Aniaro, H., and Ben-Ami, L. Factors associated with drug treatment entry patterns among hispanic women injection drug users seeking treatment. *Journal of Social Work Practice in the Addictions* 5(1- 2):157-174, 2005.

Lundgren, L.M., Schilling, R.F., Fitzgerald, T., Davis, K., and Amodeo, M. Parental Status of Women Injection Drug Users and Entry to Methadone Maintenance. *Substance Use* & *Misuse* 38(8):1109-1131, 2003.

Luty, S.E., Carter, J.D., McKenzie, J.M., Rae,

A.M., Frampton, C.M.A., Mulder, R.T., and Joyce, P.R. Randomised controlled trial of interpersonal psychotherapy and cognitive­ behavioural therapy for depression. *British Journal of Psychiatry* 190:496-502, 2007.

Lynch, W.J., Roth, M.E., and Carroll, M.E. Biological basis of sex differences in drug abuse: preclinical and clinical studies. *Psy­ chopharmacology (Berl)* 164(2):121-137,

2002.

Maguire, K., and Pastore, A.L. Sourcebook of Criminal Justice Statistics [Online]. Albany, NY: University at Albany 2001.

Maharaj, R.G., Rampersad, J., Henry, J., Khan, K.V., Koonj-Beharry, B., Mohammed, J., Rajhbeharrysingh, U., Ramkissoon, F., Sriranganathan, M., Brathwaite, B., and Barclay, S. Critical incidents contributing

to the initiation of substance use and abuse among women attending drug rehabilitation centres in Trinidad and Tobago. *West Indian Medical Journal* 54(1):51-58, 2005.

Malcolm, B.P., Hesselbrock, **M.N.,** and Se­ gal, B. Multiple substance dependence and course of alcoholism among Alaska native men and women. *Substance Use* & *Misuse* 41(5):729-741, 2006.

Mangrum, L.F., Spence, R.T., and Steinley­ Bumgarner, **M.D.** Gender differences in substance-abuse treatment clients with

co-occurring psychiatric and substance-use disorders. *Brief Treatment and Crisis Inter­ vention* 6(3):255-267, 2006.

Mann, K., Ackermann, K., Croissant, B., Mundie, G., Nakovics, H., and Diehl, A. Neuroimaging of gender differences in alco­ hol dependence: Are women more vulner­ able? *Alcoholism: Clinical and Experimental Research* 29(5):896-901, 2005.

Marcus, R.N., and Katz, J.L. Inpatient care of the substance-abusing patient with a concom­ itant eating disorder. *Hospital and Commu­ nity Psychiatry* 41(1):59-63, 1990.

Marin, G., and Marin, B.V. *Research with His­ panic Populations.* Newbury Park, CA: Sage Publications, 1991.

Marin, G., Otero-Sabogal, R., and Perez-Sta­ ble, E. MARIN Short Scale. *Hispanic Jour­ nal of Behavioral Sciences* 9:183-205, 1987.

Markides, K.S., Krause, N., and Mendes de Leon, C.F. Acculturation and alcohol con­ sumption among Mexican Americans: A three-generation study. *American Journal of Public Health* 78(9):1178-1181, 1988.

Markides, K.S., Ray, L.A., Stroup-Benham, C.A., and Trevino, F.M. Acculturation and alcohol consumption in the Mexican Ameri­ can population of the southwestern United States: Findings from HHANES 1982-84. *American Journal of Public Health* 80(Sup­ plement):42-46, 1990.

Markoff, L.S., Finkelstein, N., Kammerer, N., Kreiner, P.e., and Prost, C.A. Relational systems change: lmplementaing a model of change in integrating services for women with substance abuse and mental health disorders and histories of trauma. *Journal of Behavior Health Services* & *Research* 32(2):227-240, *2005a.*

Markoff, L.S., Reed, B.G., Fallot, R.D., El­ liott, D.E., and Bjelajac, P. Implementing trauma-informed alcohol and other drug and mental health services for women: lessons learned in a multisite demonstration proj­ ect. *American Journal of Orthopsychiatry* 75(4):525-539, *2005b.*

Markowitz, J.C. Interpersonal psychotherapy. In: Hales, R.E., and Yudofsky, S.C., eds. *The American Psychiatric Publishing Textbook of Clinical Psychiatry (4th ed.).* 1-58562-032-7 (hardcover). American Psy­ chiatric Publishing, 2003. pp. 1207-1223.

Marks, M.N., Wieck, A., Checkley, S.A., and Kumar, R. Life stress and post-partum psy­ chosis: A preliminary report. *British Journal of Psychiatry Supplement* May (10):45-49, 1991.

Marlatt, G.A., Baer, J.S., Donovan, D.M., and Kivlahan, D.R. Addictive behaviors: Etiol­ ogy and treatment. *Annual Review of Psy­ chology* 39:223-252, 1988.

Marr, D.D., and Wenner, A. Gender specific treatment for chemically dependent women: A rationale for inclusion of vocational services. *Alcoholism Treatment Quarterly* 14(1):21-31, 1996.

Martin, V., Cayla, J.A., Bolea, A., and Castilla,

J. Mycobacterium tuberculosis and human immunodeficiency virus co-infection in intra­ venous drug users on admission to prison. *International Journal of Tuberculosis and Lung Disease* 4(1):41-46, 2000.

Matthews, A.K., and Hughes, T.L. Mental health service use by African American women: Exploration of subpopulation differ­ ences. *Cultural Diversity and Ethnic Minor­ ity Psychology* 7(1):75-87, 2001.

Matthews, D.A., McCullough, M.E., Larson, D.B., Koenig, H.G., Swyers, J.P., and Milano, M.G. Religious Commitment and Health Status: A Review of the Research and Implications for Family Medicine. *Archives of Family Medicine* 7(2):118-124, 1998.

Mayes, L.C., Grillon, C., Granger, R., and Schottenfeld, **R.** Regulation of arousal and attention in preschool children exposed to cocaine prenatally. *Annals of the New York Academy of Sciences* 846:126-143, 1998.

Mayfield, D., McLeod, G., and Hall, P. The CAGE questionnaire: Validation of a new alcoholism screening instrument. *American Journal of Psychiatry* 131(10):1121-1123, 1974.

Mays, V.M., Beckman, L.J., Oranchak, E., and Harper, B. Perceived social support for help­ seeking behaviors of Black heterosexual and homosexually active women alcoholics. *Psy­ chology of Addictive Behaviors* 8(4):235-242, 1994.

Mays, V.M., Cochran, S.D., and Barnes, N.W. Race, race-based discrimination, and health outcomes among African Americans. *Annual Review of Psychology* 58(1):201-225, 2007.

Mazure, C.M., Keita, G.P., and Blehar, M.C. Summit on Women and Depression: Proceed­ ings and Recommendations. Washington, DC: American Psychological Association 2002.

McCance-Katz, E.F., Hart, C.L., Boyarsky, B., Kosten, T., and Jatlow, P. Gender effects following repeated administration of cocaine and alcohol in humans. *Substance Use* & *Misuse* 40(4):511-528, 2005.

McCoy, C.B., Comerford, M., and Metsch, L.R. Employment among chronic drug users at baseline and 6-month follow-up. *Substance Use and Misuse* 42(7):1055-1067, 2007.

McCrady, B.S., and Raytek, H.S. Women and substance abuse: Treatment modalities and outcomes. In: Gomberg, E.S., and Niren­ berg, **T.D.,** eds. *Women and Substance Abuse.* Stamford, CT: Ablex Publishing, 1993. pp. 314-338.

McCusker, **J.,** Bigelow, C., Servigon, C., and Zorn, **M.** Test-retest reliability of the Addic­ tion Severity Index composite scores among clients in residential treatment. *American Journal on Addictions* 3:254-262, 1994.

McElhatton, P.R. Heart and circulatory system drugs. In: Schaefer, C.H., ed. *Drugs Dur­ ing Pregnancy and Lactation: Handbook of Prescription Drugs and Comparative Risk Assessment: With Updated Information on Recreational Drugs.* Amsterdam: Elsevier, 2001. pp. 116-131.

McGee, G., Johnson, L., and Bell, P. *Black, Beautiful, and Recovering.* Center City, MN: Hazelden, 1985.

McGoldrick, M., Giordano, J., and Pearce,

J.K. Families of African origin: An overview. In: *Ethnicity and Family Therapy.* 2nd ed. New York: Guilford Press, 1996. pp. 57-84.

McKay, J.R., Rutherford, M.J., Cacciola, J.S., Kabasakalian-McKay, R., and Alterman,

A.I. Gender differences in the relapse experi­ ences of cocaine patients. *Journal of Nervous and Mental Disease* 184(10):616-622, 1996.

McKirnan, D.J., and Peterson, P.L. Psychoso­ cial and cultural factors in alcohol and drug abuse: An analysis of a homosexual com­ nmnity. *Addictive Behaviors* 14(5):555-563, 1989.

McKirnan, D.J., and Peterson, P.L. Gay and lesbian alcohol use: Epidemiological and psychosocial perspectives. In: Kelly, **J.,** ed. *The Research Symposium on Alcohol and Other Drug Problem Prevention Among Les­ bians and Gay Men.* Sacramento, CA: EMT Group, Inc., 1992. pp. 61-84.

McLellan, **A.T.,** Grissom, G.R., Zanis, D., Randall, M., Brill, P., and O'Brien, C.P. Problem-service 'matching' in addiction treatment: A prospective study in 4 pro­ grams. *Archives of General Psychiatry* 54(8):730-735, 1997.

McLellan, A.T., Gutman, M., Lynch, K., Mc­ Kay, **J.R.,** Ketterlinus, **R.,** Morgenstern, **J.,** and Woolis, **D.** One-year outcomes from the CASAWORKS for families intervention for substance-abusing women on welfare. *Evalu­ ation Review* 27(6):656-680, 2003.

McLellan, A.T., Luborsky, L., Cacciola, J., Griffith, **J.,** Evans, F., Barr, **H.L.,** and O'Brien, C.P. New data from the Addiction Severity Index: Reliability and validity in three centers. *Journal of Nervous and Men­ tal Disease* 173(7):412-423, 1985.

McLellan, A.T., Luborsky, L., Woody, G.E., and O'Brien, C.P. An improved diagnostic evaluation instrument for substance abuse patients: The Addiction Severity Index.

*Journal of Nervous and Mental Disease*

168(1):26-33, 1980.

McMahon, T.J., and Luthar, S.S. Bridging the gap for children as their parents enter substance abuse treatment. In: Hampton,

R.L., Senatore, V., and Gullotta, T.P., eds. *Substance Abuse, Family Violence, and Child Welfare: Bridging Perspectives.* Issues in children's and families' lives, Vol. 10.

0-7619-1457-9 (hardcover); 0-7619-1458-7

(paperback). Sage Publications, 1998. pp.

143-187.

McMurtrie, C., Rosenberg, K.D., Kerker, B.D., Kan, J., and Graham, E.H. A unique drug treatment program for pregnant and post­ partum substance-using women in New York City: Results of a pilot project, 1990-1995.

*American Journal of Drug and Alcohol Abuse* 25(4):701-713, 1999.

McNeece, C.A., and DiNitto, D.M. *Chemical Dependency: A Systems Approach.* Engle­ wood Cliffs, **N.J:** Prentice Hall, 1994.

Meara, E. Welfare reform, employment, and drug and alcohol use among low-income women. *Harvard Review of Psychiatry* 14(4):223-232, 2006.

Medina, C. Toward an understanding of Puerto Rican ethnicity and substance abuse. In: Straussner, S.L.A., ed. *Ethnocultural Fac­ tors in Substance Abuse Treatment.* New York: Guilford Press, 2001. pp. 137-163.

Mejta, C.L., and Lavin, R. Facilitating healthy parenting among mothers with substance abuse or dependence problems: Some con­ siderations. *Alcoholism Treatment Quarterly* 14(1):33-46, 1996.

Melchior, L.A., Huba, G.J., Brown, V.B., and Slaughter, R. Evaluation of the effects of outreach to women with multiple vulnerabili­ ties on entry into substance abuse treatment. *Evaluation* & *Program Planning* 22(3):269- 277, 1999.

Mello, **N.K.,** Mendelson, **J.H.,** and Teoh, S.K. Overview of the effects of alcohol on the neu­ roendocrine function in women. In: Zakhari, S., ed. *Alcohol and the Endocrine System.*

NIAAA Research Monograph No. 23. Bethes­ da, MD: National Institute on Alcohol Abuse and Alcoholism, 1993. pp. 139-169.

Melnick, S.M., and Bassuk, E.L. Identifying and responding to violence among poor and homeless women. Nashville, TN: National Health Care for the Homeless Council 2000.

Menninger, J.A. Assessment and treatment of alcoholism and substance-related disorders in the elderly. *Bulletin of the Menninger Clinic* 66(2):166-183, 2002.

Merikangas, K.R., and Stevens, D.E. Substance abuse among women: Familial factors and comorbidity. In: Wetherington, C.L., and Roman, A.B., eds. *Drug Addiction Research and the Health of Women.* NIH Publication No. 98-4290. Rockville, MD: National Insti­ tute on Drug Abuse, 1998. pp. 245-269.

Messinger, D.S., Bauer, C.R., Das, A., Seifer, R., Lester, B.M., LaGasse, L.L., Wright, L.L., Shankaran, S., Bada, H.S., Smeriglio, V.L., Langer, J.C., Beeghly, M., and Poole,

**W.K.** The maternal lifestyle study: Cognitive, motor, and behavioral outcomes of cocaine­ exposed and opiate-exposed infants through three years of age. *Pediatrics* 113(6):1677- 1685, 2004.

Metsch, L.R., McCoy, C.B., Miller, M., McAnany, H., and Pereyra, **M.** Moving sub­ stance-abusing women from welfare to work. *Journal of Public Health Policy* 20(1):36-55, 1999.

Metsch, L.R., Pereyra, M., Miles, C.C., and McCoy, C.B. Welfare and work outcomes af­ ter substance abuse treatment. *Social Service Review.* 77(2):237-254, 2003.

Metsch, L.R., Rivers, J.E., Miller, M., Bohs,

R., McCoy, C.B., Morrow, C.J., Bandstra, E.S., Jackson, V., and Gissen, M. Implemen­ tation of a family-centered treatment pro­ gram for substance-abusing women and their children: Barriers and resolutions. *Journal of Psychoactive Drugs* 27(1):73-83, 1995.

Metsch, L.R., Wolfe, H.P., Fewell, R., Mc­ Coy, C.B., Elwood, W.N., Wohler-Torres, B., Petersen-Baston, P., and Haskins, H.V. Treating substance-using women and their children in public housing: Preliminary evaluation findings. *Child Welfare Journal* 80(2):199-220, 2001.

Michaels, S. The prevalence of homosexuality in the United States. In: Cabaj, **R.P.,** and Stein, T.S., eds. *Textbook of Homosexuality*

*and Mental Health.* Washington, DC: Ameri­ can Psychiatric Press, 1996. pp. 43-63.

Midanik, L.T., Zahml, E.G., and Klein, **D.** Alcohol and drug CAGE screeners for pregnant, low-income women: The Califor­ nia perinatal needs assessment. *Alcohol­ ism: Clinical and Experimental Research* 22(1):121-125, 1998.

Miller, B.A., Downs, W.R., and Testa, M. Inter­ relationships between victimization experi­ ences and women's alcohol use. *Journal of Studies on Alcohol Supplement* 11(9):109- 117, 1993.

Miller, D. *Women Who Hurt Themselves: A Book of Hope and Understanding.* New York: Basic Books, 1994.

Miller, D., and Guidry, L. *Addictions and Trauma Recovery: Healing the Body, Mind, and Spirit.* New York: W.W. Norton, 2001.

Miller, J.B. *Toward a New Psychology of Women.* Boston: Beacon Press, 1976.

Miller, J.B. *The Development of Womens Sense of Self.* Work in Progress No. 12. Wellesley, MA: Stone Center for Developmental Ser­ vices and Studies, 1984.

Miller, S.D., Duncan, B.L., and Hubble, M.A. *Escape from Babel: Toward a Unifying Language for Psychotherapy Practice.WW* Norton & Co: New York, 1997.

Miller, W.R. Rediscovering fire: Small interven­ tions, large effects. *Psychology of Addictive Behaviors* 14(1):6-18, 2000.

Miller, W.R., and Rollnick, S. *Motivational Interviewing: Preparing People to Change Addictive Behavior.* New York: Guilford Press, 1991.

Miller, W.R., and Rollnick, S. *Motivational Interviewing: Preparing Peoplefor Change.* 2nd ed. New York: Guilford Press, 2002.

Miller, W.R., Tonigan, J.S., and Longabaugh,

**R.** *The Drinker Inventory of Consequences (DrlnC): An lnstmment For Assessing Adverse Consequences of Alcohol Abuse.* Project **MATCH** Monograph Series Vol. 4. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism, 1995.

Minino, **A.M.,** Arias, E., Kochanek, **K.D.,** Murphy, S.L., and Smith, B.L. *Deaths: Final Data for 2000.* National Vital Statistics Reports: Vol. 50, no. 15. Hyattsville, **MD:** National Center for Health Statistics, 2002.

Mokuau, N. Health and well-being for Pacific Islanders: Status, barriers, and resolutions. In: Mokuau, N., Epstein, L.G., Pacheco, G., and Quinlan, **J.W.,** eds. *Responding to*

*Pacific Islanders: Culturally Competent Per­ specti,ves For Substance Abuse Prevention.*

CSAP Cultural Competence Series 8. HHS Publication No. (SMA)98-3195. Rockville, MD: Center for Substance Abuse Prevention, 1998a. pp. 1-24.

Mokuau, N. Reality and vision: A cultural perspective in addressing alcohol and drug abuse among Pacific Islanders. In: Mokuau, N., Epstein, L.G., Pacheco, G., and Quin­ lan, J.W., eds. *Responding to Pacific Island­ ers: Culturally Competent Perspectives For Substance Abuse Prevention.* CSAP Cultural Competence Series 8. HHS Publication No. (SMA)98-3195. Rockville, MD: Center for Substance Abuse Prevention, 1998b. pp.

25-47.

Moncrieff, J., and Farmer, R. Sexual abuse and the subsequent development of alcohol prob­ lems. *Alcohol and Alcoholism* 33(6):592-601, 1998.

Mondanaro, J. Medical services for drug de­ pendent women. In: Beschner, G.M., Reed, B.G., and Mondanaro, J., eds. *Treatment Services for Drug Dependent Women: Vol. 1.* HHS Publication No. (ADM) 81-1177. Rock­ ville, MD: National Institute on Drug Abuse, 1981. pp. 208-257.

Moore, J., and Finkelstein, N. Parenting servic­ es for families affected by substance abuse.

*Child Welfare* 80(2):221-238, 2001.

Moore, R.D., Bone, L.R., Geller, G., Mamon, J.A., Stokes, E.J., andLevine, D.M. Preva­ lence, detection, and treatment of alcoholism in hospitalized patients. *JAMA* 261(3):403- 407, 1989.

Moos, R.H., Moos, B.S., and Timko, C. Gen­ der, treatment and self-help in remission from alcohol use disorders. *Clinical Medicine* & *Research* 4(3):163-174, 2006.

Moos, R.H., Schutte, K., Brennan, P., and Moos, B.S. Ten-year patterns of alcohol consumption and drinking problems among older women and men. *Addiction* 99(7):829- 838, 2004.

Mora, J. The treatment of alcohol dependency among Latinas: A feminist, cultural and com­ munity perspective. *Alcoholism Treatment Quarterly* 16(1-2):163-177, 1998.

Mora, J. Latinas in cultural transition: Addic­ tion, treatment and recovery. In: Straussner, S.L.A., and Brown, S., eds. *The Handbook of Addiction Treatment for Women: Theory and Practice.* San Francisco: Jossey Bass, 2002. pp. 323-347.

Morgen, C.S., Bove, **K.B.,** Larsen, K.S., Kjaer, S.K., and Gronbaek, M. Association Between Smoking and the Risk of Heavy Drinking Among Young Women: A Prospective Study. *Alcohol and Alcoholism,* 2008.

Morgenstern, J., Blanchard, K.A., McCrady, B.S., McVeigh, K.H., Morgan, T.J., and Pandina, R.J. Effectiveness of intensive case management for substance-dependent women receiving temporary assistance for needy families. *American Journal of Public Health* 96(11):2016-2023, 2006.

Morgenstern, J., McCrady, B.S., Blanchard, K.A., McVeigh, K.H., Riordan, A., and Irwin, T.W. Barriers to employability among substance dependent and nonsubstance­ affected women on federal welfare: implica­ tions for program design. *Journal of Studies on Alcohol* 64(2):239-246, 2003.

Morrissey, J.P., Ellis, A.R., Gatz, M., Amaro, H., Reed, B.G., Savage, A., Finkelstein, N., Mazelis, R., Brown, V., Jackson, E.W., and Banks, S. Outcomes for women with co-oc­ curring disorders and trauma: program and person-level effects. *Journal of Substance Abuse Treatment* 28(2):121-133, 2005a.

Morrissey, J.P., Jackson, E.W., Ellis, A.R., Amaro, H., Brown, V.B., and Najavits, L.M. Twelve-month outcomes of trauma-informed interventions for women with co-occurring disorders. *Psychiatric Services* 56(10):1213- 1222, 2005b.

Morse, B., Gehshan, S., and Hutchins, E. *Screening for Substance Abuse During Preg­ nancy: Improving Care, Improving Health.* Arlington, VA: National Center for Educa­ tion in Maternal and Child Health, 1997.

Moscato, B.S., Russell, M., Zielezny, M., Bromet, E., Egri, G., Mudar, P., and Mar­ shall, **J.R.** Gender differences in the relation between depressive symptoms and alcohol problems: A longitudinal perspective. *Ameri­ can Journal of Epidemiology* 146(11):966- 974, 1997.

Moses, D.J., Huntington, N., and D'Ambrosio,

B. *Developing Integrated Services for Wom­ en with Co-Occurring Disorders and Trauma Histories: Lessons from the SAMHSA Women with Alcohol, Drug Abuse and Mental Health Disorders Who Have Histories of Violence Study.* Rockville, MD: Substance Abuse

and Mental Health Services Administration, 2004.

Moses, D.J., Reed, B.G., Mazelis, R., and D'Ambrosio, B. *Creating Trauma Ser-vices for Women With Co-Occurring Disorders: Experiences from the SAMHSA Women with Alcohol, Drug Abuse and Mental Health Disorders Who Have Histories of Violence Study.* Women, Co-Occurring Disorders & Violence Study. Rockville, MD: Substance Abuse And Mental Health Services Adminis­ tration, 2003.

Mrazek, P.B., Haggerty, R.J., Institute of Medi­ cine, Committee on Prevention of Mental Disorders, United States, and Congress.

*Reducing Risks For Mental Disorders: Fron­ tiers For Preventive Intervention Research.* Washington, D.C: National Academy Press, 1994.

Mucha, **L.,** Stephenson, J., Morandi, N., and Dirani, R. Meta-analysis of disease risk asso­ ciated with smoking, by gender and intensity of smoking. *Gender Medicine* 3(4):279-291, 2006.

Mullen, P.D. How can more smoking suspension during pregnancy become lifelong absti­ nence? Lessons learned about predictors, interventions, and gaps in our accumulated knowledge. *Nicotine* & *Tobacco Research* 6(Suppl2):S217-S238, 2004.

Mumenthaler, M.S., Taylor, J.L., O'Hara, R., and Yesavage, J.A. Gender differences in moderate drinking effects. *Alcohol Research and Health* 23(1):55-64, 1999.

Mumola, C.J. Incarcerated Parents and Their Children. *Bureau of Justice Statistics Spe­ cial Report* Washington, DC: Bureau of Jus­ tice Statistics, 2000.

Mumola, C.J., and Karberg, J.C. Drug use and dependence, State and Federal prisoners, 2004. *Bureau of Justice Statistics Special Report* Washington, DC: U.S. Department of Justice, 2007.

Musgrave, C.F., Allen, C.E., and Allen,

G.J. Spirituality and health for women of color. *American Journal of Public Health* 92(4):557-560, 2002.

Najavits, L.M. Training clinicians in the Seeking Safety treatment protocol for posttraumatic stress disorder and substance abuse. *Alcohol­ ism Treatment Quarterly* 18(3):83-98, 2000.

Najavits, L.M. *A womans addiction workbook: Your guide to in-depth healing.* Oakland, CA: New Harbinger, *2002a.*

Najavits, L.M. *Seeking safety: A treatment manual for PTSD and substance abuse.* New York: Guilford Press, *2002b.*

Najavits, L.M. Treatment of posttraumatic stress disorder and substance abuse: clinical guidelines for implementing "Seeking Safety" therapy. *Alcoholism Treatment Quarterly* 22(1):43-62, 2004.

Najavits, L.M. Managing trauma reactions in intensive addiction treatment environments. *Journal of Chemical Dependency Treatment* 8:153-161, 2006.

Najavits, L.M. Seeking safety: An evidence­ based model for substance abuse and trauma/PTSD. In: Witkiewitz, K.A., and Marlatt, G.A., eds. *Therapist's Guide to Evidence-Based Relapse Prevention.* Prac­ tical Resources for the Mental Health Pro­ fessional. Boston, MA: Elsevier Academic Press, 2007. pp. 141-168.

Najavits, L.M., Gallop, R.J., and Weiss, R.D. Seeking safety therapy for adolescent girls with PTSD and substance use disorder: a randomized controlled trial. *Journal of Be­ havior Health Services Research* 33(4):453- 463, 2006.

Najavits, L.M., Runkel, R., Neuner, C., Frank, A.F., Thase, M.E., Crits-Christoph, P., and Elaine, J. Rates and Symptoms of PTSD among cocaine-dependent patients. *Journal of Studies on Alcohol* 64(5):601-606, 2003.

Najavits, L.M., Schmitz, M., Gotthardt, S., and Weiss, R.D. Seeking safety plus exposure therapy: An outcome study on dual diag­ nosis men. *Journal of Psychoactive Drugs* 37(4):425-435, 2005.

Najavits, L.M., Weiss, R.D., and Liese, B. Group cognitive-behavioral therapy for women with PTSD and substance use disor­ der. *Journal of Substance Abuse Treatment* 13(1):13-22, 1996.

Najavits, L.M., Weiss, R.D., and Shaw, S.R. The link between substance abuse and posttraumatic stress disorder in women: A research review. *American Journal on Addic­ tions* 6(4):273-283, 1997.

Najavits, L.M., Weiss, R.D., Shaw, S.R., and Muenz, L.R. "Seeking Safety": Outcome of a new cognitive-behavioral psychotherapy

for women with posttraumatic stress disorder and substance dependence. *Journal of Trau­ matic Stress* 11(3):437-456, 1998.

Nanchahal, K., Ashton, W.D., and Wood, D.A. Alcohol consumption, metabolic cardiovascu­ lar risk factors and hypertension in women. *International Journal of Epidemiology* 29(1):57-64, 2000.

Nardi, D. Addiction recovery for low-income pregnant and parenting women: A process of becoming. *Archives of Psychiatric Nursing* 12(2):81-89, 1998.

National Alliance for Caregiving and AARP, Caregiving in the U.S. Bethesda, MD: Na­ tional Alliance for Caregiving 2004.

National Association for Children of Alcoholics. Celebrating Families Model. 2007. Available on-line at: http://www.celebratingfamilies. net/CFmodel.htm

National Center on Addiction and Substance Abuse. Substance abuse and the American woman. New York: National Center on Ad­ diction and Substance Abuse, 1996.

National Center on Addiction and Substance Abuse. *Depression, Substance Abuse and College Student Engagement: A Review of the Literature Report to the Charles Engel­ hard Foundation and the Bringing Theory to Practice Planning Group.* New York, NY: National Center on Addiction and Substance Abuse at Columbia University 2003.

National Coalition of Anti-Violence Programs.

*Lesbian, Gay, Bisexual and Transgender Do­ mestic Violence in the United States in 2006: A Report Of The National Coalition Of Anti­ Violence Programs.* New York, NY: National Coalition of Anti-Violence Programs, 2007.

National Institute of Diabetes and Digestive and Kidney Diseases. *Binge Eating Disorders.*

Bethesda, MD: National Institute of Diabetes and Digestive and Kidney Diseases, 2001.

National Institute of Mental Health. *Anxiety Disorders.* NIH Publication No. 06-3879 Bethesda, MD: National Institutes of Health, 2007.

National Institute on Drug Abuse. *Principles Of Drug Addiction Treatment: A Research­ Based Guide.* NIH Publication No. 00-4180.

Bethesda, MD: National Institutes of Health,

1999.

National Institute on Drug Abuse. Heroin: Abuse and Addiction. *National Institute on Drug Abuse Research Report Series* Rock­ ville, MD: National Institute on Drug Abuse, 2000.

National Institute on Drug Almse. Prescription drugs: Abuse and addiction. *National Insti­ tute on Drug Abuse Research Report Series* Rockville, MD: National Institute on Drug Almse 2001.

National Institute on Drug Abuse. Behavioral problems related to maternal smoking during pregnancy manifest early in childhood. *NIDA Notes* 21(6):7-8, 2008.

National Institutes of Health - Office of Re­ search on Women's Health. *Women of Color Health Data Book: Adolescents to Seniors.* Bethesda, MD: National Institutes of Health, Office of Research on Women's Health, 1999.

National Poverty Center. *Poverty in the United States: Frequently Asked Questions.* Ann Arbor, Ml: University of Michigan 2006.

Neff, J.A., and Mantz, R.J. Marital status tran­ sition, alcohol consumption, and number of sex partners over time in a tri-ethnic sample. *Journal of Divorce and Remarriage* 29(1- 2):19-42, 1998.

Nelson-Zlupko, L., Kauffman, E., and Dore,

**M.M.** Gender differences in drug addiction and treatment: implications for social work intervention with substance-abusing women. *Soc Work* 40(1):45-54, 1995.

Nelson-Zlupko, L., Dore, M.M., Kauffman,

E., and Kaltenbach, K. Women in recovery: Their perceptions of treatment effective­ ness. *Journal of Substance Abuse Treatment* 13(1):51-59, 1996.

Neumarker, K.J. Mortality and sudden death in anorexia nervosa. *International Journal of Eating Disorders* 21(3):205-212, 1997.

Neuspiel, D.R. Racism and perinatal addiction.

*Ethnicity and Disease* 6(1-2):47-55, 1996.

New York State Education Department -- Office of Bilingual Education. *Directory of Lan­ guages.* Albany, NY: New York State Educa­ tion Department, Office of Bilingual Educa­ tion, 1997.

Newmann, J.P., and Sallmann, J. Women, trau­ ma histories, and co-occurring disorders: Assessing the scope of the problem. *Social Service Review* 78(3):446-499, 2004.

Niccols, A., and Sword, W. "New Choices" for substance-using mothers and their children: Preliminary evaluation. *Journal of Sub­ stance Use* 10(4):239-251, 2005.

Nicoloff, L.K., and Stiglitz, E.A. Lesbian alco­ holism: Etiology, treatment, and recovery. In: Boston Lesbian Psychologies Collective, ed. *Lesbian psychologies: Explorations and challenges.* Urbana, IL: University of Illinois Press, 1987. pp. 283-293.

Nielsen Forman, D., Videbech, P., Hedegaard, M., Dalby, S.J., and Secher, N.J. Postpar­ tum depression: Identification of women at risk. *BJOG: An International Jozirnal of Ob­ stetrics and Gynaecology* 107(10):1210-1217, 2000.

Nikolopoulou, G.B., Nowicki, M.J., Du, W., Homans, J., Stek, A., Kramer, F., and Kovacs, A. HCV viremia is associated with drug use in young HIV-1 and HCV coinfected pregnant and non-pregnant women. *Addic­ tion* 100(5):626-635, 2005.

Nishimoto, **R.H.,** and Roberts, A.C. Coercion and drug treatment for postpartum women. *American Journal of Drug Alcohol Abuse* 27(1):161-181, 2001.

Nishith, P., Resick, P.A., and Mueser, K.T. Sleep difficulties and alcohol use motives in female rape victims with posttraumatic

stress disorder. *Journal of Traumatic Stress*

14(3):469-479, 2001.

Niv, N., and Hser, Y.I. Women-only and mixed­ gender drug abuse treatment programs: ser­ vice needs, utilization and outcomes. *Drug and Alcohol Dependence* 87(2-3):194-201,

2007.

Niv, N., Wong, E.C., and Hser, Y.I. Asian Americans in community-based substance abuse treatment: service needs, utilization, and outcomes. *Journal of Substance Abuse Treatment* 33(3):313-319, 2007.

Norris, J., and Hughes, T.L. Alcohol consump­ tion and female sexuality: A review. In: Howard, **J.M.,** Martin, S.E., Mail, **P.D.,** Hilton, M.E., and Taylor, E.D., eds. *Women and Alcohol: Issues for Prevention Research.* NIAAA Research Monograph No. 32. Bethes­ da, MD: National Institute on Alcohol Abuse and Alcoholism, 1996. pp. 315-345.

North, C.S., Eyrich, K.M., Pollio, D.E., and Spitznagel, E.L. Are rates of psychiatric disorders in the homeless population chang­ ing? *American Journal of Public Health* 94(1):103-108, *2004a.*

North, C.S., Eyrich, **K.M.,** Pollio, D.E., Foster, D.A., Cottier, L.B., and Spitznagel, E.L. The Homeless Supplement to the Diagnos-

tic Interview Schedule: test-retest analyses. *International Journal of Methods in Psychi­ atric Research* 13(3):184---191, *2004b.*

Oates, M. Management of major mental illness in pregnancy and the puerperium. *Baillieres Best Practice and Research: Clinical Obstet­ rics and Gynaecology* 3(4):905-920, 1989.

Oetjen, H., and Rothblum, E.D. When lesbi­ ans aren't gay: Factors affecting depression among lesbians. *Journal of Homosexuality* 39(1):49-73, 2000.

Oetzel, J., Duran, B., Jiang, Y., and Lucero,

J. Social support and social undermining as correlates for alcohol, drug, and mental dis­ orders in American Indian women presenting for primary care at an Indian Health Service hospital. *Journal of Health Communication* 12(2):187-206, 2007.

Office of Applied Studies. *Results from the 2001 National Household Survey on Drug Abuse: Vol.I. Summary of National Findings.*

National Household Survey on Drug Abuse Series: H-17. HHS Publication No. (SMA) 02-3758. Rockville, **MD:** Substance Abuse and Mental Health Services Administration, *2002a.*

Office of Applied Studies. *Results from the 2001 National Household Survey on Drug Abuse: Volume III. Detailed Tables.* Rockville, **MD:** Substance Almse and **Mental** Health Services Administration, *2002b.*

Office of Applied Studies. Characteristics of homeless female admissions to substance abuse treatment: 2002. *The DASIS Report* (October 8, 2004): Rockville, M.D.: Sub­ stance Abuse and Mental Health Services Administration *2004a.*

Office of Applied Studies. Gender differences in substance dependence and abuse. *The NS­ DUH Report* (October 29, 2004): Rockville, MD: Substance Abuse and Mental Health Services Administration *2004b.*

Office of Applied Studies. Women with co-occur­ ring serious mental illness and a substance use disorder. *The NSDUH Report* (August 20, 2004):1-3. Rockville, **MD:** Substance Abuse and **Mental** Health Services Adminis­ **tration** 2004c.

Office of Applied Studies. *Results from the 2004 National Survey on Drug Use and Health: National Findings.* HHS Publication No.

SMA 05-4062 Rockville, MD: Substance Abuse and Mental Health Services Adminis­ tration 2005.

Office of Applied Studies. Facilities offering special programs or groups for women: 2005. *The DASIS Report* Issue 35 Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006.

Office of Management and Budget. Recommen­ dations from the lnteragency Committee for the review of the racial and ethnic standards to the Office of Management and Budget Concerning Changes to the Standards for the Classification of Federal Data on Race and Ethnicity. *Federal Register* 62(13):36873- 36946, 1997.

Office of National Drug Control Policy. *Nation­ al Drug Control Strategy.* Washington, DC: Office of National Drug Control Policy, 2007.

Office of the Surgeon General. Fact Sheets: Asian Americans/Pacific Islanders. *Mental Health: Culture, Race, and Ethnicity A Supplement to Mental Health: A Report of the Surgeon General* Rockville, **MD:** U.S. Public Health Service 2001a.

Office of the Surgeon General. *Women and Smoking: A Report of the Surgeon General.* Atlanta, GA: Centers for Disease Control and Prevention, Office on Smoking and Health 2001b.

O'Hara, M.W., Stuart, S., Gorman, L.L., and Wenzel, A. Efficacy of interpersonal psycho­ therapy for postpartum depression. *Archives of General Psychiatry* 57(11):1039-1045, 2000.

Okazaki, S. Psychological assessment of Asian Americans: Research agenda for cultural competency. *Journal of Personality Assess­ ment* 70(1):54-70, 1998.

Oklahoma Department of Mental Health and Substance Abuse Services. Title 450. Depart­ ment of Mental Health and Substance Abuse Services. chapter 18. *Standards and Criteria for Alcohol and Drug Treatment Programs.* Oklahoma City, OK: Oklahoma Department of Mental Health and Substance Abuse Ser­ vices, 2008.

Oncology Nursing Society 31st Annual Congress Podium and Poster Abstracts. *Oncology Nursing Forum* 33(2):394--491, 2006.

Onland-Moret, N.C., Peeters, P.H., Van Der Schouw, Y.T., Grobbee, D.E., and van Gils,

C.H. Alcohol and endogenous sex steroid levels in postmenopausal women: a cross-sec­ tional study. *Journal of Clinical Endocrinol­ ogy and Metabolism* 90(3):1414-1419, 2005.

Oregon Secretary of State, and Department of Human Services, A.S. *Standards for Out­ patient and Residential Alcohol and Drug Treatment Programs.* Salem, OR: Oregon Secretary of State, 2008.

Orenstein, R., and Tsogas, N. Hepatitis C virus and human immunodeficiency virus co­ infection in women. *Journal of the American Osteopathic Association* 101(12 Suppl Pt 2):Sl-S6, 2001.

Ouimette, P.C., Kimerling, R., Shaw, J., and Moos, R.H. Physical and sexual abuse among women and men with substance use disorders. *Alcoholism Treatment Quarterly* 18(3):7-17, 2000.

Page, R.M. Perceived physical attractiveness and frequency of substance use among male and female adolescents. *Journal of Alcohol and Drug Education* 38(2):81-91, 1993.

Paniagua, F.A. *Assessing and Treating Cultur­ ally Diverse Clients: A Practical Guide.* 2d ed. Thousand Oaks, CA: Sage Publications, 1998.

Paranjape, A., and Liebschutz, J. STaT: a three-question screen for intimate partner violence. *Journal of Womens Health (Larch­ ment)* 12(3):233-239, 2003.

Parelman, A. *Emotional Intimacy in Mar­ riage: A Sex-Roles Perspective. Research in Clinical Psychology.* Ann Arbor, Mich: UMI Research Press, 1983.

Parks, C.A. Lesbian identity development: An examination of differences across genera­ tions. *American Journal of Orthopsychiatry* 69(3):347-361, 1999a.

Parks, C.A. Lesbian social drinking: The role of alcohol in growing up and living as a lesbian. *Contemporary Drug Problems* 26(1):75-129, 1999b.

Parks, C.A., and Hughes, T.L. Alcohol use and alcohol-related problems in self-identified lesbians: age and racial/ethnic comparisons. *Journal of Lesbian Studies* 9(3):31-44, 2005.

Parks, C.A., Hesselbrock, **M.N.,** Hesselbrock, V.M., and Segal, B. Factors affecting entry into substance abuse treatment: Gender dif­ ferences among alcohol-dependent Alaska Natives. *Social Work Research* 27(3):151- 161, 2003.

Passaro, K.T., and Little, R.E. Childbearing and alcohol use. In: Wilsnack, **R.W.,** and Wilsnack, S.C., eds. *Gender and Alcohol: Individual and Social Perspectives.* New Brunswick, NJ: Rutgers Center of Alcohol Studies, 1997. pp. 90-113.

Patkar, A.A., Sterling, R.C., Gottheil, E., and Weinstein, S**.P.** A comparison of medical symptoms reported by cocaine-, opiate-, and alcohol-dependent patients. *Substance Abuse* 20(4):227-235, 1999.

Pedersen, P.B., Fukuyama, M., and Heath, A. Client, counselor, and contextual variables in multicultural counseling. In: Pedersen, P.B., Draguns, J.G., Lonner, W.J., and Trimble, J.E., eds. *Counseling Across Cultures.* 3d ed. Honolulu, HI: University of Hawaii Press, 1989. pp. 23-52.

Pelissier, B. Gender differences in substance use treatment entry and retention among prison­ ers with substance use histories. *American Journal of Public Health* 94(8):1418-1424, 2004.

Peluso, E., and Peluso, L.S. *Women and Drugs: Getting Hooked, Getting Clean.* Minneapo­ lis, MN: CompCare Publishers, 1988.

Penn, P.E., Brooks, A.J., and Worsham, B.D. Treatment concerns of women with co-oc­ curring serious mental illness and substance abuse disorders. *Journal of Psychoactive Drugs* 34(4):355-362, 2002.

Peters, T.J., Millward, **L.M.,** and Foster, **J.** Quality of life in alcohol misuse: Compari­ son of men and women. *Archives of Womens Mental Health* 6(4):239-243, 2003.

Pettinati, H.M., Rukstalis, M.R., Luck, G.J., Volpicelli, J.R., and O'Brien, C.P. Gender and psychiatric comorbidity: Impact on clinical presentation of alcohol dependence. *American Journal on Addictions* 9(3):242- 252, 2000.

Piazza, N.J., Vrbka, J.L., and Yeager, R.D. Telescoping of alcoholism in women alcohol­ ics. *International Journal of the Addictions* 24(1):19-28, 1989.

Pickens, R.W., Svikis, D.S., McGue, M., Lyk­

ken, D.T., Heston, L.L., and Clayton, **P.J.** Heterogeneity in the inheritance of alco­ holism: A study of male and female twins. *Archives of General Psychiatry* 48(1):19-28, 1991.

Piran, N., and Robinson, S.R. Associations between disordered eating behaviors and licit and illicit substance use and abuse in a university sample. *Addictive Behaviors* 31(10):1761-1775, 2006.

Pomerleau, C.S., Zucker, A.N., and Stewart,

A.J. Characterizing concerns about post­ cessation weight gain: results from a national survey of women smokers. *Nicotine and Tobacco Research* 3(1):51-60, 2001.

Poole, N., and Dell, C.A. *Girls, Women and Substance Use.* 1-16. Ottawa, ON: Canadian Centre on Substance Abuse 2005.

Porter, **L.** *Women and HCV: Treatment. HCSP Factsheet* June version 1.0 San Francisco, CA: Hepatitis C Support Project, 2005.

Porter, **L.K.** *Women and Hepatitis C: An HCSP Guide.* San Francisco, CA: Hepatits C Sup­ port Project, 2008.

Poundstone, K.E., Chaisson, R.E., and Moore,

R.D. Differences in HIV disease progression by injection drug use and by sex in the era of highly active antiretroviral therapy. *AIDS* 15(9):1115-1123, 2001.

Power, C., Rodgers, B., and Hope, S. Heavy al­ cohol consumption and marital status: Disen­ tangling the relationship in a national study of young adults. *Addiction* 94(10):1477-1487, 1999.

Prescott, C.A. Sex differences in the genetic risk for alcoholism. *Alcohol Research* & *Health* 26(4):264-273, 2002.

Prescott, L. *Consumer/Survivor/Recovering Women: A Guide for Partnerships in Col­ laboration.* Delmar, NY: Policy Research Associates, 2001.

Price, A., and Simmel, C. *Partners' Influ­ ence on Womens Addiction and Recovery: The Connection Between Substance Abuse,*

*Trauma, and Intimate Relationships.* Berke­ ley, CA: University of California at Berkeley, School of Social Welfare, National Aban­ doned Infants Assistance Resource Center, 2002.

Prochaska, **J.J.,** Delucchi, K., and Hall, S.M. A meta-analysis of smoking cessation inter­ ventions with individuals in substance abuse treatment or recovery. *Journal of Consult­ ing* & *Clinical Psychology* 72(6):1144-1156, 2004.

Project MATCH Research Group. Project MATCH secondary a priori hypotheses. *Ad­ diction* 92(12):1671-1698, 1997.

Pugatch, D., Ramratmanm M., Strong, L., Feller, A., and Levesque, B. Gender differ­ ences in HIV risk behaviors among young adults and adolescents entering a Massachu­ setts detoxification center. *Substance Abuse* 21(2):79-86, 2000.

Quinlivan, J.A., and Evans, S.F. The impact of continuing illegal drug use on teenage preg­ nancy outcomes--a prospective cohort study. *BJOG: An International Journal of Obstet­ rics and Gynaecology* 109(10):1148-1153, 2002.

Radloff, L.S. The CES-D Scale: A self-report depression scale for research in the general population. *Applied Psychological Measure­ ment* 1(3):385--401, 1977.

Raeburn, S.D. Women and eating disorders.

In: Straussner, S.L.A., and Brown, S., eds. *The Handbook of Addiction Treatment for Women: Theory and Practice.* San Francis­ co: Jossey-Bass, 2002. pp. 127-153.

Randall, C.L. Alcohol and pregnancy: High­ lights from three decades of research. *Jour­ nal of Studies on Alcohol* 62(5):554-561, 2001.

Randolph, W.M., Stroup-Benham, C., Black, S.A., and Markides, K.S. Alcohol use among Cuban-Americans, Mexican-Americans, and Puerto Ricans. *Alcohol Health and Research World* 22(4):265-269, 1998.

Ratner, P.A., Johnson, J.L., Bottorff, J.L., Dahinten, S., and Hall, W. Twelve-month follow-up of a smoking relapse prevention intervention for postpartum women. *Addic­ tive Behaviors* 25(1):81-92, 2000.

Ravndal, E., and Vaglum, P. Treatment of female addicts: the importance of relation­ ships to parents, partners, and peers for the outcome. *International Journal of Addic­ tions* 29(1):115-125, 1994.

Rayburn, W.F., and Bogenschutz, M.P. Phar­ macotherapy for pregnant women with ad­ dictions. *American Journal of Obstetrics and Gynecology* 191(6):1885-1897, 2004.

Reed, B.G., and Mowbray, C.T. Mental illness and substance abuse: Implications for wom­ en's health and health care access. *Journal of the American Medical Womens Associa­ tion* 54(2):71-78, 1999.

Reeves, T., and Bennett, C. The Asian and Pacific Islander population in the United States: March 2002. *Current Psychiatry Re­ ports* Washington, DC: U. S. Census Bureau 2003.

Register, T.C., Cline, **J.M.,** and Shively, C.A. Health issues in postmenopausal women who drink. *Alcohol Research* & *Health* 26(4):299-307, 2002.

Register, T.C., Cline, J.M., and Shively, C.A. *Health Issues in Postmenopausal Women Who Drink.* Bethesda, MD: National Insti­ tute on Alcohol Abuse and Alcoholism, 2003.

Reid, D.J. Addiction, African Americans, and a Christian recovery. In: Krestan, **J**.A., ed. *Bridges to Recovery: Addiction, Family*

*Therapy, and Multicultural Treatment.* New York: The Free Press, 2000. pp. 145-172.

Renzetti, C.M. Violence in lesbian relation­ ships. In: Hansen, M., and Harway, **M.,** eds. *Battering and Family Therapy: A Feminist Perspective.* Thousand Oaks, CA: Sage Pub­ lications, 1993.pp. 188-199.

Renzetti, C.M. On dancing with a bear: Reflec­ tions on some of the current debates among domestic violence theorists. *Violence and Victims* 9(2):195-200, 1994.

Reyes, M. Latina lesbians and alcohol and other drugs: Social work implications. *Alcoholism Treatment Quarterly* 16(1/2):179-192, 1998.

Reynolds, E.W., and Bada, H.S. Pharmacology of drugs of abuse. *Obstetrics and Gynecol­ ogy Clinics of North America* 30(3):501-522, 2003.

Rhoades, J.A., and Chu, M.C. Health insurance status of the civilian noninstitutionalized population: 1999. Rockville, MD: Agency for Healthcare Research and Quality 2000.

Rhodes, R., and Johnson, A. A feminist ap­ proach to treating alcohol and drug-addicted African-American women. *Women* & *Thera­ py* 20(3):23-37, 1997.

Rice, C., Mohr, C.D., DelBoca, F.K., Mattson, M.E., Young, L., Brady, K., and Nickless, C. Self-reports of physical, sexual and emotion­ al abuse in an alcoholism treatment sample. *Journal of Studies onAlcohol* 62(1):114-123, 2001.

Richardson, G.A., Goldschmidt, L., and Lark­ by, C. Effects of prenatal cocaine exposure on growth: a longitudinal analysis. *Pediatrics* 120(4):el017-el027, 2007.

Ridenour, T.A., Maldonado-Molina, M., Comp­ ton, **W.M.,** Spitznagel, E.L., and Cottler,

L.B. Factors associated with the transition from abuse to dependence among substance abusers: implications for a measure of addic­ tive liability. *Drug and Alcohol Dependence* 80(1):1-14, 2005.

Riehman, K.S., Hser, Y.I., and Zeller, M. Gender differences in how intimate partners influence drug treatment motivation. *Journal of Drug Issues* 30(4):823-838, 2000.

Riehman, K.S., lguchi, M.Y., Zeller, M., and Morral, A.R. The influence of partner drug use and relationship power on treatment engagement. *Drug and Alcohol Dependence* 70(1):1-10, 2003.

Rinehart, D.J., Becker, M.A., Buckley, P.R., Dailey, K., Reichardt, c.S., Graeber, C., VanDeMark, N.R., and Brown, E. The relationship between mothers' child abuse potential and current metal health symp­ toms: Implications for screening and refer­ ral. *Journal of Behavior Health Services* & *Research* 32(2):155-166, 2005.

Roberts, A., Jackson, M.S., and Carlton­ LaNey, I. Revisiting the need for feminism and afrocentric theory when treating Afri­ can-American female substance abusers. *Journal of Drug Issues* 30(4):901-918, 2000.

Roberts, A.C., and Nishimoto, **R.** Barriers to engaging and retaining African American post-partum women in drug treatment. *Jour­ nal of Drug Issues* 36(1):53-76, 2006.

Roberts, A.C., and Nishimoto, R.H. Predict­ ing treatment retention of women dependent on cocaine. *American Journal of Drug and Alcohol Abuse* 22(3):313-333, 1996.

Robertson, M.J., Zlotnick, C., and Westerfelt,

A. Drug use disorders and treatment contact among homeless adults in Alameda County, California. *American Journal of Public Health* 87(2):221-228, 1997.

Robin, R.W., Chester, B., Rasmussen, J.K., and Jaranson, J.M. Factors influencing utilization of mental health and substance abuse services by American Indian men and women. *Psychiatric Services* 48(6):826-832, 1997.

Rodriguez-Andrew, S. Alcohol use and abuse among Latinos: Issues and examples of cul­ turally competent services. *Alcoholism Treat­ ment Quarterly* 16(1-2):55-70, 1998.

Rogers, C. Older women and poverty in rural America. *Rural Population and Migration: Trend 6-Challenges From an Aging Popula­ tion* Washington, DC: U.S. Department of Agriculture, 2005.

Rohan, T.E., Jain, M., Howe, G.R., and Miller,

A.B. Alcohol consumption and risk of breast cancer: A cohort study. *Cancer Causes and Control* 11(3):239-247, 2000.

Romach, M.K., and Sellers, E.M. Alcohol dependence: Women, biology, and pharma­ cotherapy. In: McCance-Katz, E.F., and Ko­ sten, T.R., eds. *New Treatments for Chemi­ cal Addictions.* Washington, DC: American Psychiatric Press, 1998. pp. 35-73.

Rome, E.S. Eating disorders. *Obstetrics and Gynecology Clinics of North America* 30(2):353-377, 2003.

Root, **M.P.** Treatment failures: The role of sexual victimization in women's addictive behavior. *American Journal of Orthopsy­ chiatry* 59(4):542-549, 1989.

Rosenberg, L., Palmer, J.R., Rao, R.S., and Adams-Campbell, L.L. Patterns and corre­ lates of alcohol consumption among African­ American women. *Ethnicity and Disease* 12(4):548-554, 2002.

Ross, J. Food addiction: A new look at the nature of craving. *Addiction and Recovery* 13(5):17-19, 1993.

Ross-Durow, P.L., and Boyd, C.J. Sexual abuse, depression, and eating disorders in African American women who smoke co­ caine. *Journal of Substance Abuse Treatment* 18(1):79-81, 2000.

Rotgers, F. Clinically useful, research validated assessment of persons with alcohol prob­ lems. *Behaviour Research and Therapy* 40(12):1425-1441, 2002.

Rotter, J.C., and Casado, M. Promoting strengths and celebrating culture: Work­ ing with Hispanic families. *Family Journal* 6(2):132-137, 1998.

Rouse, B.A., Carter, J.H., and Rodriguez-An­ drew, S. Race/ethnicity and other sociocul­ tural influences on alcoholism treatment for women. In: Galanter, M., ed. *Recent Devel­ opments in Alcoholism, Vol. 12: Alcoholism and Women.* New York: Plenum Press, 1995. pp. 343-367.

Rubin, A., Stout, R.L., and Longabaugh, R. Gender differences **in** relapse situations. *Ad­ diction* 9l(Suppl):Slll-Sl20, 1996.

Rush, **M.M.** Perceived social support: Dimen­ sions of social interaction among sober fe­ male participants in Alcoholics Anonymous. *Journal of the American Psychiatric Nurses Association* 8(4):114-119, 2002.

Russell, **M.** New assessment tools for risk drink­ ing during pregnancy: T-ACE, TWEAK, and others. *Alcohol Health and Research World* 18(1):55-61, 1994.

Russell, **M.,** Czarnecki, D.M., Cowan, R., McPherson, E., and Mudar, P.J. Measures of maternal alcohol use as predictors of development in early childhood. *Alcohol­ ism: Clinical* & *Experimental Research* 15(6):991-1000, 1991.

Russell, M., Martier, S.S., Sokol, R.J., Mudar, P., Jacobson, S., and Jacobson, J. Detecting risk drinking during pregnancy: A compari­ son of four screening questionnaires. *Ameri­ can Journal of Public Health* 86(10):1435- 1439, 1996.

Russell, P.L. Trauma and the cognitive function of affects. In: Teicholz, J.G., and Kriegman, D., eds. *Trauma, Repetition, and Affect Regulation: The Work of Paul Russell.* New York: The Other Press, 1998. pp. 23-47.

Ryland, S.A., and Lucas, L. A rural collabora­ tive model of treatment and recovery services for pregnant and parenting women with dual disorders. *Journal of Psychoactive Drugs* 28(4):389-395, 1996.

Sabol, W.J., Couture, H., and Harrison, P.M. Prisoners in 2006. *Bureau of Justice Statis­ tics Bulletin* Washington, DC: U.S. Depart­ ment of Justice 2007.

Safer, D.L., Telch, C.F., and Agras, W.S. Dia­ lectical behavior therapy adapted for buli­ mia: A case report. *International Journal of Eating Disorders* 30(1):101-106, 2001.

Salasin, S.E. Evolution of women's trauma­ integrated services at the Substance Abuse and Mental Health Services Administra­ tion. *Journal of Community Psychology* 33(4):379-393, 2005.

Sale, E., Sambrano, S., Springer, **J.F.,** Pena, C., Pan, W.,and Kasim, **R.** Family protec­ tion and prevention of alcohol use among Hispanic youth at high risk. *American Jour­ nal of Commimity Psychology* 36(3-4):195- 205, 2005.

Salmon, M.M., Joseph, B.M., Saylor, C., and Mann, R.J. Women's perception of provider, social, and program support in an outpatient drug treatment program. *Journal of Sub­ stance Abuse Treatment* 19(3):239-246, 2000.

Sampson, H.W. Alcohol's harmful effects on bone. *Alcohol Health and Research World* 22(3):190-194, 1998.

Sampson, H.W. Alcohol and other factors af­ fecting osteoporosis risk in women. *Alcohol Research* & *Health* 26(4):292-298, 2002.

Sandfort, T.G., de Graaf, R., Bijl, R.V., and Schnabel, P. Same-sex sexual behavior and psychiatric disorders: Findings from the Netherlands Mental Health Survey and Inci­ dence Study (NEMESIS). *Archives of Gen­ eral Psychiatry* 58(1):85-91, 2001.

Santen, F.J., Sofsky, J., Bilic, N., and Lip­ pert, R. Mechanism of action of narcotics in the production of menstrual dysfunction in women. *Fertility and Sterility* 26(6):538-548, 1975.

Sartor, C.E., Lynskey, M.T., Bucholz, K.K., McCutcheon, V.V., Nelson, E.C., Waldron, M., and Heath, A.C. Childhood sexual abuse and the course of alcohol dependence devel­ opment: Findings from a female twin sample. *Drug and Alcohol Dependence* 89(2-3):139- 144, 2007.

Satre, D.D., Mertens, J.R., andWeisner, C. Gender differences in treatment outcomes for alcohol dependence among older adults.

*Journal of Studies on Alcohol* 65(5):638-642, 2004.

Saunders, E.J. A new model of residential care for substance-abusing women and their children. *Adult Residential Care Journal* 7(2):104-117, 1993.

Saylors, K., and Daliparthy, N. Violence against Native women in substance abuse treatment. *American Indian and Alaska Native Mental Health Research* 13(1):32-51, 2006.

Schauer, C., Everett, A., del, V.P., and Ander­ son, L. Promoting the value and practice

of shared decision-making **in** mental health care. *Psychiatric Rehabilitation Journal* 31(1):54-61, 2007.

Schilit, R., Lie, G.Y., and Montagne, M. Sub­ stance use as a correlate of violence in intimate lesbian relationships. *Journal of Homosexuality* 19(3):51-65, 1990.

Schnoll, R.A., Patterson, F., and Lerman, C.

Treating tobacco dependence in women. *Journal of Womens Health (Larchmt.)* 16(8):1211-1218, 2007.

Schuck, A.M., and Widom, C.S. Childhood vic­ timization and alcohol symptoms in females: causal inferences and hypothesized media­ tors. *Child Abuse and Neglect* 25(8):1069- 1092, 2001.

Schweinsburg, B.C., Alhassoon, O.M., Taylor, M.J., Gonzalez, R., Videen, J.S., Brown, G.G., Patterson, T.L., and Grant, I. Ef­ fects of alcoholism and gender on brain metabolism. *American Journal of Psychiatry* 160(6):1180-1183, 2003.

Scogin, F., Morthland, M., Kaufman, A., Bur­ gio, L., Chaplin, W., Kong, G., and'. Im­ proving quality of life in diverse rural older adults: A randomized trial of a psychological treatment. *Psychology and Aging* 22(4):657- 665, 2007.

Scott-Lennox, J., Rose, R., Bohlig, A., and Len­ nox, R. The impact of women's family status on completion of substance abuse treatment. *Journal of Behavioral Health Services and Research* 27(4):366-379, 2000.

Setiawan, V.W., Monroe, K.R., Goodman, M.T., Kolonel, L.N., Pike, M.C., and Hen­ derson, B.E. Alcohol consumption and endo­ metrial cancer risk: the multiethnic cohort. *International Journal of Cancer* 122(3):634- 638, 2008.

Severance, **T.A.** Concerns and coping strategies of women inmates concerning release: "It's going to take somebody in my corner." *Jour­ nal of Offender Rehabilitation* 38(4): 73-97,

2004.

Sheehan, D., Janavs, J., Baker, R., Harnett­ Sheehan, K., Knapp, E., Sheehan, M., Lecrubier, Y., Weiller, E., Hergueta, T., Amorim, P., Bonora, L.I., and Lepine, J.P. *M.I.N.I.: Mini International Neuropsychi­ atric Interview.* English Version 5.0.0. n.p.: Medical Outcome Systems 2002.

Sherman, C. Drugs Affect Men's and Women's Brains Differently. NIDA Notes vol. 20:6 2006.

Shieh, C., and Kravitz, M. Severity of drug use, initiation of prenatal care, and maternal­ fetal attachment in pregnant marijuana and cocaine/heroin users. *Journal of Obstetric, Gynecologic,* & *Neonatal Nursing: Clinical Scholarship for the Care of Women, Child­ bearing Families,* & *Newborns* 35(4):499- 508, 2006.

Shiffman, S., and Balabanis, M. Associations between alcohol and tobacco. In: Fertig, J.B., and Allen, J.P., eds. *Alcohol and To­ bacco: From Basic Science to Clinical Prac­ tice.* NIAAA Research Monograph No. 30. Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism, 1995. pp. 17-36.

Silverman, J.G., Raj, A., and Clements, K. Dating violence and associated sexual risk and pregnancy among adolescent girls in the United States. *Pediatrics* 114(2):e220-e225, 2004.

Silverman, J.G., Raj, A., Mucci, L.A., and Hathaway, J.E. Dating violence against adolescent girls and associated substance use, unhealthy weight control, sexual risk behavior, pregnancy, and suicidality. *Jour­ nal of the American Medical Association* 286(5):572-579, 2001.

Silverstein, B. Women show higher rates of anxious somatic depression but maybe not "pure" depression. *Clinicians Research Digest* 20(10):3, 2002.

Simoni, J.M., Sehgal, S., and Walters, K.L. Triangle of risk: urban American Indian women's sexual trauma, injection drug use, and HIV sexual risk behaviors. *AIDS and Behavior* 8(1):33--45, 2004.

Simoni-Wastila, L. The use of abusable pre­ scription drugs: The role of gender. *Journal of Womens Health and Gender-Based Medi­ cine* 9(3):289-297, 2000.

Simpson, **D.D.** *Patient Engagement and Dura­ tion of Treatment.* Bethesda, MD: National Institute on Drug Abuse, 1997.

Simpson, D.D., and Knight, D.K. TCU Data Collection Forms for Women and Children Residential Treatment: Intake. Fort Worth, TX: Texas Christian University, Institute of Behavioral Research, 1997.

Simpson, T.L. Childhood sexual abuse, PTSD and the functional roles of alcohol use among women drinkers. *Substance Use* & *Misuse* 38(2):249-270, 2003.

Singer, **L.T.,** Arendt, **R.,** Minnes, S., Farkas, K., and Salvator, A. Neurobehavioral out­ comes of cocaine-exposed infants. *Neurotoxi­ cology and Teratology* 22(5):653-666, 2000.

Singer, **L.T.,** Minnes, S., Short, E., Arendt, **R.,**

Farkas, K., Lewis, B., Klein, N., Russ, S., Min, M.O., and Kirchner, H.L. Cognitive outcomes of preschool children with prenatal cocaine exposure. *JAMA* 291(20):2448-2456, 2004.

Singletary, K.W., and Gapstur, S.M. Alcohol and breast cancer: Review of epidemiologic and experimental evidence and potential mechanisms. *Journal of the American Medi­ cal Association* 286(17):2143-2151, 2001.

Slade, A., and Cohen, L.J. The process of par­ enting and the remembrance of things past. *Infant Mental Health Journal* 17(3):217- 238, 1996.

Slaymaker, V.J., and Owen, P.L. Employed men and women substance abusers: Job troubles and treatment outcomes. *Journal of Sub­ stance Abuse Treatment* 31(4):347-354, 2006.

Smith, C., and Erford, B.T. *Test Review: Beck Depression Inventory* - *II.* Greensboro, NC: Association for Assessment in Counseling, 2001.

Smith, D.E., Moser, C., Wesson, D.R., Apter,

M., Buxton, M.E., Davison, **J.V.,** Orgel, M., and Buffum, J. A clinical guide to the diag­ nosis and treatment of heroin-related sexual dysfunction. *Journal of Psychoactive Drugs* 14(1-2):91-99, 1982.

Smith, J. W. Medical manifestations of alcohol­ ism in the elderly. *International Journal of the Addictions* 30(13-14):1749-1798, 1995.

Smith, L.M., LaGasse, L.L., Derauf, C., Grant, P., Shah, R., Arria, A., Huestis, M., Han­

ing, W., Strauss, A., Della, G.S., Liu, J., and Lester, B.M. The infant development, environment, and lifestyle study: Effects of prenatal methamphetamine exposure, poly­ drug exposure, and poverty on intrauterine growth. *Pediatrics* 118(3):1149-1156, 2006.

Smith, S.S., Jorenby, D.E., Leischow, S.J.,

Nides, M.A., Rennard, S.I., Johnston, J.A., Jamerson, B., Fiore, M.C., and Baker,

T.B. Targeting smokers at increased risk for relapse: treating women and those with a history of depression. *Nicotine and Tobacco Research* 5(1):99-109, 2003.

Smolak, L., and Murnen, S.K. Gender and eat­ ing problems. In: Striegel-Moore, R.H., and Smolak, L., eds. *Eating Disorders: Innova­ tive Directions in Research and Practice.*

1-55798-778-5 (hardcover). American Psy­ chological Association: Washington, 2001. pp. 91-110.

Sobell, L.C., Cunningham, J.A., and Sobell,

**M.B.** Recovery from alcohol problems with and without treatment: Prevalence in two population surveys. *American Journal of Public Health* 86(7):966-972, 1996.

Sohrabji, F. Neurodegeneration in women. *Alco­ hol Research* & *Health* 26(4):316-318, 2002.

Sokol, R.J., and Clarren, S.K. Guidelines for use of terminology describing the impact of prenatal alcohol on the offspring. *Alcohol­ ism: Clinical and Experimental Research* 13(4):597-598, 1989.

Sokol, R.J., Martier, S.S., and Ager, J.W. The T-ACE questions: practical prenatal detec­ tion of risk-drinking. *American Journal of Obstetrics and Gynecology* 160(4):863-868, 1989.

Solarz, A.L. (Ed.) *Lesbian Health: Current Assessment And Directions For The Fu­ ture.* Washington, D.C.: National Academy Press, 1999.

Solomon, S.D., and Johnson, D.M. Psychoso­ cial treatment of posttraumatic stress disor­ der: A practice-friendly review of outcome research. *Journal of Clinical Psychology* 58(8):947-959, 2002.

Sorensen, **J.L.,** Masson, C.L., Delucchi, K., Sporer, K., Barnett, P.G., Mitsuishi, F., Lin, C., Song, Y., Chen, T., and Hall, S.M. Randomized trial of drug abuse treatment­ linkage strategies. *Journal of Consulting* & *Clinical Psychology* 73(6):1026-1035, 2005.

Specker, S., Westermeyer, J., and Thuras, P. Course and severity of substance abuse in women with comorbid eating disorders. *Sub­ stance Abuse* 21(3):137-147, 2000.

Stahler, G.J., Shipley, T.E., Kirby, K.C., God­ boldte, C., Kerwin, M.E., Shandler, I., and Simons, L. Development and initial demon­ stration of a community-based intervention for homeless, cocaine-using, African-Amer­ ican Women. *Journal of Substance Abuse Treatment* 28(2):171-179, 2005.

Stamler, V.L., Christiansen, **M.D.,** Staley, **K.H., and** agno-Shang, L. Client preference for counselor gender. *Psychology of Women Quarterly* 15(2):317-321, 1991.

Steele, C.T. Providing clinical treatment to sub­ stance abusing trauma survivors. *Alcoholism Treatment Quarterly* 18(3):71-82, 2000.

Steer, R.A., Beck, A.T., and Brown, G. Sex differences on the revised Beck Depression Inventory for outpatients with affective disorders. *Journal of Personality Assessment* 53(4):693-702, 1989.

Steffens, A.A., Moreira, L.B., Fuchs, S.C., Wiehe, M., Gus, M., and Fuchs, F.D. Inci­ dence of hypertension by alcohol consump­ tion: is it modified by race? *Journal of Hypertension* 24(8):1489-1492, 2006.

Steinberg, **M.B.,** Akincigil, A., Delnevo, C.D., Crystal, S., and Carson, **J.L.** Gender and age disparities for smoking-cessation treat­ ment. *American Journal of Preventive Medi­ cine* 30(5):405-412, 2006.

Steiner, M. Perinatal mood disorders: Posi­ tion paper. *Psychopharmacology Bulletin* 34(3):301-306, 1998.

Steiner, M. Postnatal depression: A few simple questions. *Family Practice* 19(5):469-470, 2002.

Steinhausen, H.C. The outcome of anorexia nervosa in the 20th century. *American Jour­ nal of Psychiatry* 159(8):1284-1293, 2002.

Sterling, R.C., Gottheil, E., Weinstein, S.P., and Serota, R. Therapist/patient race and sex matching: Treatment retention and

9-month follow-up outcome. *Addiction*

93(7):1043-1050, 1998.

Stevens, **S.J.** American-Indian women and health. In: Wechsberg, **W.M.,** ed. *Prevention issues for womens health in the new mil­ lennium.* Binghamton, NY: Haworth Press, 2001. pp. 97-109.

Stevens, S.J., and Estrada, B. *Substance involved women: Ethnic differences, contra­ ceptive practices and HIV sex risk behaviors.* Presented at the Society for Menstrual Cycle Research Biennial Conference, Tucson, AZ, June, 1999.

Stevens, S.J., and Murphy, B.S. *Womens-Spe­ cific Health Assessment.* Tucson, AZ: Uni­ versity of Arizona, Southwest Institute for Research on Women, 1998.

Stevens, **S.J.,** and Patton, T. Residential treat­ ment for drug addicted women and their children: Effective treatment strategies. In: Stevens, S.J., and Wexler, H.K., eds. *Women and Substance Abuse: Gender Transpar­ ency.* New York: Haworth Press, 1998a. pp. 235-249.

Stevens, S.J., and Patton, T. Residential treat­ ment for drug addicted women and their chil­ dren: Effective treatment strategies. *Drugs* & *Society* 13(1/2):235-249, 1998b.

Stevens, S.J., Estrada, A.L., and Estrada, B.D. HIV sex and drug risk behavior and behav­ ior change in a national sample of injection drug and crack cocaine using women. *Women* & *Health* 27(1-2):25-48, 1998.

Stewart, D.E. *Menopause: A Mental Health Practitioners Guide.* 1st ed ed. Washington, DC: American Psychiatric Pub, 2005.

Stewart, S.H., Conrod, P.J., Samoluk, S.B., Pihl, R.O., and Dongier, M. Posttraumatic stress disorder symptoms and situation-spe­ cific drinking in women substance abusers. *Alcoholism Treatment Quarterly* 18(3):31- 47, 2000.

Strantz, I.H., and Welch, S.P. Postpartum women in outpatient drug abuse treatment: Correlates of retention/completion. *Journal of Psychoactive Drugs* 27(4):357-373, 1995.

Stratton, K., Howe, C., and Battaglia, F. (Eds.) *Fetal Alcohol Syndrome: Diagnosis, Epide­ miology, Prevention, and Treatment.* Wash­ ington, DC: National Academy Press, 1996.

Stromwall, L.K., and Larson, N.C. Women's ex­ perience of co-occurring substance abuse and mental health conditions. *Journal of Social Work Practice in the Addictions* 4(1):81-96, 2004.

Substance Almse and Mental Health Adminis­ tration. Blueprint for change: Ending chron­ ic homelessness for persons with serious mental illnesses and co-occurring substance use disorders. HHS Pub. No. SMA-04-3870 Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2003a.

Substance Abuse and Mental Health Services Administration. *Questions About Sexual Abuse.* Women, Violence and Co-Occurring Disorders Grant. TI 98-004. Unpublished instrument, 2003b.

Substance Almse and Mental Health Services Administration. *Results from the 2003 National Survey on Drug Use and Health: National Findings.* (Office of Applied Stud­ ies, NSDUH Series: H-25, HHS Publication No. SMA 04-3964). Rockville, MD, 2004.

Substance Abuse and Mental Health Ser-

vices Administration. *Recovery Community Services Program.* Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Adminis­ tration, *2006a.*

Substance Abuse and Mental Health Services Administration. *Results from the 2005 Na­ tional Survey on Drug Use and Health: Na­ tional Findings.* HHS Publication No. SMA 06-4194 Rockville, MD: Office of Applied Studies, *2006b.*

Substance Abuse and Mental Health Services Administration. *Results from the 2006 National Survey on Drug Use and Health: National Findings.* HHS Publication No. SMA SMA 07-4293 Rockville, MD: Office of Applied Studies, 2007.

Substance Almse and Mental Health Services Administration. *Results from the 2007 National Survey on Drug Use and Health: National Findings.* (Office of Applied Stud­ ies, NSDUH Series H-34, HHS Publication No.SMA 08-4343) 2008.

Substance Almse and Mental Health Services Administration, and Office of Applied Stud­ ies. *Treatment Episode Data Set (TEDS): 1992-2000. National Admissions to Sub­ stance Abuse Treatment Services.* Drug and Alcohol Services Information System Series: S-17. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2002.

Substance Almse and Mental Health Services Administration, and Office of Applied Stud­ ies. *Overview of Findings from the 2002 National Survey on Drug Use and Health.* (Office of Applied Studies, NHSDA Series H-21, HHS Publication No. SMA 03-3774).

Rockville, MD: Substance Almse and Mental Health Services Administration, 2003.

Substance Almse and Mental Health Services Administration, and Office of Applied Stud­ ies. Table 4.llb. Facility services offered, by facility operation: March 31, 2003. *National Survey of Substance Abuse Treatment Ser­ vices (N-SSATS): 2003 Data on Substance Abuse Treatment Facilities* Rockville, MD, 2004a.

Substance Abuse and Mental Health Services Administration and Office of Applied Stud­ ies. *Treatment Episode Data Set (TEDS). Highlights* - *2002. National Admissions to Substance Abuse Treatment Services, DASIS Series: S-22* HHS Publication No. (SMA)

04-3946 Rockville, **MD:** Substance Abuse and Mental Health Services Administration, 2004b.

Substance Almse and Mental Health Services Administration, Office of Applied Studies. Treatment Episode Data Set (TEDS): 1992- 2002. National Admissions to Substance Abuse Treatment Services. HHS Publication No. (SMA) 04-3965 Rockville, MD: Sub­ stance Abuse and Mental Health Services Administration, 2004c.

Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *The National SZLrvey of SZLbstance AbZLse Treatment Services: 2003. The DASIS Report* (March 11, 2005): Rockville, **MD:**

Substance Abuse and Mental Health Services Administration 2005a.

Substance Abuse and Mental Health Services Administration, Office of Applied Stud- ies. Treatment Episode Data Set (TEDS). Highlights - 2003. *National Admissions to*

*SZLbstance AbZLse Treatment Services, DASIS Series: S-27* HHS Publication No. (SMA)

05-4043 Rockville, **MD:** Substance Abuse and Mental Health Services Administration 2005b.

Substance Abuse and Mental Health Services Administration, Office of Applied Stud- ies. *National SZLrvey of SZLbstance AbZLse*

*Treatment Services (N-SSATS): 2005. Data on SZLbstance AbZLse Treatment Facilities.*

DASIS Series: S-34. HHS Publication No. (SMA) 06-4206. Rockville, MD: Substance Abuse and Mental Health Services Adminis­ tration, 2006.

Substance Abuse and Mental Health Services Administration and Office of Applied Stud­ ies. Gender differences in alcohol use and al­ cohol dependence or abuse: 2004 and 2005. *The NSDUH Report* April 2, 2007a.

Substance Abuse and Mental Health Services Administration, Office of Applied Studies. Hispanic female admissions in substance abuse treatment: 2005. *The DASIS Report* April 13 Rockville, MD, 2007b.

Substance Abuse and Mental Health Services Administration, Office of Applied Studies. Treatment Admissions with Medicaid as the Primary expected or Actual Payment source: 2005. *The DASIS Report* July 12

Rockville, MD: Substance Abuse and Mental Health Services Administration 2007*c.*

Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *Remltsfrom the 2007 National Survey on Dmg Use and Health: National Findings.* (Office of Applied Studies, NSDUH Series H-34, HHS Publication No. SMA 08-4343) Rockville, **MD:** Office of Applied Studies, 2008.

Suchman, N., Mayes, L., Conti, **J.,** Slade, A., and Rounsaville, B. Rethinking parenting interventions for drug-dependent mothers: From behavior management to fostering emo­ tional bonds. *]oZLrnal of SZLbstance AbZLse Treatment* 27(3):179-185, 2004.

Suchman, N., Pajulo, M., DeCoste, C., and Mayes, L. Parenting interventions for drug­ dependent mothers and their young children: The case for an attachment-based approach. *Family Relations* 55(2):211-226, 2006.

Suchman, N.E., Rounsaville, B., DeCoste, C., and Luthar, S. Parental control, parental warmth, and psychosocial adjustment in a sample of substance-abusing mothers and their school-aged and adolescent children.

*]oZLrnal of SZLbstance AbZLse Treatment*

32(1):1-10, 2007.

Sue, D.W., and Sue, **D.** *Counseling the Cultur­ ally Different: Theory and Practice.* 3d ed. New York: John Wiley and Sons, 1999.

Sue, D.W., and Sue, **D.** *Counseling the Cultur­ ally Diverse: Theory and Practice.* 4th ed. New York: John Wiley and Sons, 2003.

Sullivan, E.V., Fama, R., Rosenbloom, M.J., and Pfefferbaum, A. A profile of neurop­ sychological deficits in alcoholic women.

*Neuropsychology* 16(1):74-83, 2002.

Sullivan, J.M., and Evans, K. Integrated treat­ ment for the survivor of childhood trauma who is chemically dependent. *Journal of Psychoactive Drugs* 26(4):369-378, 1994.

Sullivan, J. T., Sykora, K., Schneiderman, J., Naranjo, C.A., and Sellers, E.M. Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for alcohol scale (CIWA-Ar). *British Journal of Addic­ tion* 84(11):1353-1357, 1989.

Sun, A.P. Helping substance-abusing mothers in the child-welfare system: Turning crisis into opportunity. *Families in Society* 81(2):142- 151, 2000.

Sun, A.P. Program factors related to women's substance abuse treatment retention and oth­ er outcomes: A review and critique. *Journal of Substance Abuse Treatment* 30(1):1-20, 2006.

Sun, A.P. Relapse among substance-abusing women: Components and processes. *Sub­ stance Use and Misuse* 42(1):1-21, 2007.

Sussman, S. Smoking cessation among persons in recovery. *Substance Use* & *Misuse* 37(8- 10):1275-1298, 2002.

Swan, G.E., and Denk, C.E. Dynamic models for the maintenance of smoking cessation: event history analysis oflate relapse. *Journal of Behavioral Medicine* 10(6):527-554, 1987.

Swan, S., Farber, S., and Campbell, D. Vio­ lence in the lives of women in substance abuse treatment: Service and policy implica­ tions. *Report to the New York State Office of the Prevention of Domestic Violence.* Rens­ selear, NY: Author, 2000.

Sylvestre, D.L., and Zweben, J.E. Integrat- ing HCV services for drug users: a model to improve engagement and outcomes. *Interna­*

*tional Journal of Drug Policy* 18(5):406-410, 2007.

Szuster, R.R., Rich, L.L., Chung, A., and Bis­ coner, S.W. Treatment retention in women's residential chemical dependency treatment: The effect of admission with children. *Sub­ stance Use and Misiise* 31(8):1001-1013, 1996.

Tafoya, T., and Roeder, K.R. Spiritual exiles in their own homelands: Gays, lesbians and Na­ tive Americans. *Journal of Chemical Depen­ dency Treatment* 5(2):179-197, 1995.

Tatum, T. Rural women's recovery program and women's outreach: Serving rural Appala­ chian women and families in Ohio. In: Center for Substance Abuse Treatment, ed. *Treating Alcohol and Other Drug Abusers in Rural and Frontier Areas.* Technical Assistance Publication Series 17. HHS Publication

No. (SMA) 99-3339. Rockville, MD: Center for Substance Abuse Treatment, 1995. pp. 13-20.

Taylor, T.R., Williams, C.D., Makambi, K.H., Mouton, C., Harrell, J.P., Cozier, Y., Palm­ er, J.R., Rosenberg, L., and dams-Campbell,

L.L. Racial discrimination and breast cancer incidence in us black women: The black women's health study. *American Journal of Epidemiology* 166(1):46-54, 2007.

Terner, **J.M.,** and de Wit, **H.** Menstrual cycle phase and responses to drugs of abuse in humans. *Drug and Alcohol Dependence* 84(1):1-13, 2006.

Testa, M., Livingston, J.A., and Leonard, K.E. Women's substance use and experiences of intimate partner violence: A longitudinal investigation among a community sample.

*Addictive Behaviors* 28(9):1649-1664, 2003.

Teusch, R. Substance-abusing women and sexual abuse. In: Straussner, S.L.A., and Zelvin, E., eds. *Gender and Addictions: Men and Women in Treatment.* Northvale, NJ: Jason Aronson, 1997. pp. 97-122.

Thaithumyanon, P., Limpongsanurak, S., Praisuwanna, P., and Punnahitanon, S. Perinatal effects of amphetamine and heroin use during pregnancy on the mother and infant. *Journal of the Medical Association of Thailand* 88(11):1506-1513, 2005.

The C. Everett Koop Institute. **High** risk Groups - United States. *Hepatitis C: An Epi­ demic for Anyone* Hanover, NH: Dartmouth Medical School, 2008.

Theall, K.P., Sterk, C.E., and Elifson, K. Illicit drug use and women's sexual and reproduc­ tive health. In: Wingood, G.M., and DiCle­ mente, R.J., eds. *Handbook ofWomens Sexual and Reproductive Health.* New York, NY: Kluwer Academic/Plenum Publishers, 2002. pp. 129-152.

Thevos, A.K., Roberts, J.S., Thomas, S.E., and Randall, C.L. Cognitive behavioral therapy delays relapse in female socially phobic alco­ holics. *Addictive Behaviors* 25(3):333-345, 2000.

Thom, B. Sex differences in help-seeking for al­ cohol problems: I. The barriers to help-seek­ ing. *British Journal of Addiction* 81(6):777- 788, 1986.

Thom, B. Sex differences in help-seeking for alcohol problems: II. Entry into treatment. *British Journal of Addiction* 82(9):989-997, 1987.

Thomasson, **H.** Alcohol elimination: Faster **in** women? *Alcoholism: Clinical and Experi­ mental Research* 24(4):419-420, 2000.

Thompson, R.S., Bonomi, A.E., Anderson, M., Reid, R.J., Dimer, J.A., Carrell, D., and Ri­ vara, F.P. Intimate partner violence: preva­ lence, types, and chronicity in adult women. *American Journal of Preventive Medicine* 30(6):447-457, 2006.

Thornberry, J., Bhaskar, B., Krulewitch, C.J., Wesley, B., Hubbard, M.L., Das, A., Foud­ in, L., and Adamson, M. Audio computerized self-report interview use in prenatal clinics: Audio computer-assisted self interview with touch screen to detect alcohol consumption

in pregnant women. Application of a new technology to an old problem. *Computers, Informatics, Nursing* 20(2):46-52, 2002.

Thorpe, L.E., Frederick, M., Pitt, J., Cheng, I., Watts, D.H., Buschur, S., Green, K., Zorrilla, C., Landesman, S.H., and Her­ show, R. C. Effect of hard-drug use on CD4 cell percentage, HIV RNA level, and progres­ sion to AIDS-defining class C events among HIV-infected women. *Journal of Acquired Immune Deficiency Syndromes* 37(3):1423- 1430, 2004.

Tiemersma, E.W., Wark, P.A., Oclce, M.C., Bunschoten, A., Otten, M.H., Kok, F.J., and Kampman, E. Alcohol Consumption, Alco­ hol Dehydrogenase 3 Polymorphism, and Colorectal Adenomas. *Cancer Epidemiology Biomarkers Prevention* 12(5):419-425, 2003.

Timko, C., Moos, **R.H.,** Finney, J.W., and Con­ nell, E.G. Gender differences in help-utiliza­ tion and the 8-year course of alcohol abuse. *Addiction* 97(7):877-889, 2002.

Timko, C., Sutkowi, A., Pavao, **J.,** and Kim­ erling, R. Women's childhood and adult ad­ verse experiences, mental health, and binge drinking: The California Women's Health Survey. *Substance Abuse Treatment, Preven­ tion and Policy* 3(1):15, 2008.

Tjaden, P., and Thoennes, N. Prevalence, Inci­ dence, and Consequences of Violence Against Women: Findings from the National Violence Against Women Survey. *National Institute of Justice I Centers for Disease Control Pre­ vention Research in Brief* Washington, DC: National Institute of Justice, 1998.

Tjaden, P., and Thoennes, N. Extent, nature, and consequences of intimate partner vio­ lence. *Findings From the National Violence Against Women Survey* (July):NCJ 181867 Washington, D.C.: U.S. Department of Jus­ tice, 2000.

Tjaden, P., and Thoennes, N. Extent, nature, and consequences of rape victimization: Findings from the National Violence Against Women Survey. *Findings From the National Violence Against Women Survey* Washington, DC: U.S. Department of Justice, National Institute of Justice, 2006.

Tolin, D.F., and Foa, E.B. Sex differences in trauma and posttraumatic stress disorder: A quantitative review of 25 years of research. *Psychological Bulletin* 132(6):959-992, 2006.

Tolstrup, J.S., Kjaer, S.K., Holst, C., Sharif, H., Munk, C., Osler, M., Schmidt, L., Andersen, A.M., and Gronbaek, M. Alcohol use as predictor for infertility in a repre­ sentative population of Danish women. *Acta Obstetricia Et Gynecologica Scandinavica* 82(8):744-749, 2003.

Tonigan, J.S., and Miller, W.R. The inven­ tory of drug use consequences (lnDUC): test-retest stability and sensitivity to detect change. *Psychology of Addictive Behaviors* 16(2):165-168, 2002.

Torabi, M.R., Bailey, W.J., and Majd-Jabbari,

M. Cigarette smoking as a predictor of alcohol and other drug use by children and adolescents: Evidence of the "gateway drug effect." *Journal of School Health* 63(7):302- 306, 1993.

Torsch, V.L., and Xueqin Ma, G. Cross-cultural comparison of health perceptions, concerns, and coping strategies among Asian and Pa­ cific Islander American elders. *Qualitative Health Research* 10(4):471--489, 2000.

Tough, S., Tofflemire, K., Clarke, M., and Newburn-Cook, C. Do women change their drinking behaviors while trying to conceive? An opportunity for preconception counsel­ ing. *Clinical Medicine and Research* 4(2):97- 105, 2006.

Tourangeau, R., and Smith, T.W. Asking sensi­ tive questions: The impact of data collection mode, question format, and question con­ text. *Public Opinion Quarterly* 60(2):275- 304, 1996.

Towle, **L.H.** Japanese-American drinking: Some results from the Joint Japanese-U.S. Alcohol Epidemiology Project. *Alcohol Health and Research World* 12(3):216-223, 1988.

Tracy, E.M., and Martin, T.C. Children's roles in the social networks of women in substance abuse treatment. *Journal of Substance Abuse Treatment* 32(1):81-88, 2007.

Trepper, T.S., McCollum, E.E., Dankoski, M.E., Davis, S.K., and LaFazia, M.A. Cou­ ples therapy for drug abusing women in an inpatient setting: A pilot study. *Contempo­ rary Family Therapy* 22(2):201-221, 2000.

Triffleman, E. Gender differences in a con­ trolled pilot study of psychosocial treatment in substance dependent patients with post­ traumatic stress disorder: Design consider­ ations and outcomes. *Alcoholism Treatment Quarterly* 13(3):113-126, 2000.

Triffleman, E. Issues in implementing post­ traumatic stress disorder treatment outcome research in community-based treatment programs. In: Sorensen, J.L., Rawson, R.A., Guydish, J., and Zweben, J.E., eds. *Drug Abuse Treatment Through Collaboration: Practice and Research Partnerships that Work.* 1-55798-985-0 (hardcover). Ameri­ can Psychological Association: Washington, 2003. pp. 227-247.

Trimble, J.E., andJumper Thurman, P. Eth­ nocultural considerations and strategies for providing counseling services to Native

American Indians. In: Pedersen, P.B., Dra­ guns, J.G., Lonner, W.J., and Trimble, J.E., eds. *Counseling Across Cultures.* Thousand Oaks, CA: Sage, 2002. pp. 53-91.

Tronick, E.Z., and Beeghly, M. Prenatal co­ caine exposure, child development, and the compromising effects of cumulative risk.

*Clinics in Perinatology* 26(1):151-171, 1999.

Tuten, M., and Jones, H.E. A partner's drug­ using status impacts women's drug treatment outcome. *Drug and Alcohol Dependence* 70(3):327-330, 2003.

Tuten, M., Jones, H.E., Tran, G., and Svikis,

D.S. Partner violence impacts the psycho­ social and psychiatric status of pregnant, drug-dependent women. *Addictive Behaviors* 29(5):1029-1034, 2004.

Ullman, S.E., Filipas, **H.H.,** Townsend, S.M., and Starzynski, **L.L.** Trauma exposure, posttraumatic stress disorder and problem drinking in sexual assault survivors. *Journal of Studies on Alcohol* 66(5):610-619, 2005.

Underhill, B.L., and Ostermann, S.E. The pain of invisibility: Issues for lesbians. In: Roth, P., ed. *Alcohol and Drugs Are Wom­ en's Issues: Vol. 1. A Review of the Issues.* Metuchen, NJ: Scarecrow Press, 1991. pp. 71-77.

United Nations General Assembly. *Declara­ tion on the Elimination of Violence Against Women. AIRES/48/104* New York: United Nations, 1993.

Urbano-Marquez, A., Estruch, R., Fernandez­ Sola, J., Nicolas, J.M., Pare, J.C., and Ru­ bin, E. The greater risk of alcoholic cardio­ myopathy and myopathy in women compared with men. *Journal of the American Medical Association* 274(2):149-154, 1995.

U.S. Census Bureau. *Census Bureau Projects Doubling of Nation's Population by 2100.* Washington, DC: U.S. Census Bureau, *2000a.*

U.S. Census Bureau. *Projections of the Total Resident Population by 5-Year Age Groups, Race, and Hispanic Origin, with Special Age Categories: Middle Series, 2050 to 2070.* Washington, DC: U.S. Census Bureau, *2000b.*

U.S. Census Bureau. *Census 2000 PHC-T-10: Hispanic or Latino Origin for the United States, Regions, Divisions, States, andfor Puerto Rico..* Washington, DC: U.S. Census Bureau, 2001a.

U.S. Census Bureau. *Profile of General De­ mographic Characteristics for the United States: 2000.* Washington, DC: U.S. Census Bureau, 2001b.

U.S. Census Bureau. *Statistical Abstract of the United States, 2001: The National Data*

*Book.* Washington, DC: U.S. Census Bureau, 2001c.

U.S. Census Bureau. Table 1: Male-female ratio by race alone or in combination and His­ panic or Latino origin for the United States. 2000. Washington, DC: U.S. Census Bureau, 2001d.

U.S. Census Bureau. Table 1: Population by race and Hispanic or Latino origin, for all ages and for 18 years and over, for the

United States. 2000. Washington, DC: U.S. Census Bureau, 200le.

U.S. Census Bureau. Table 2: Percent of popu­ lation by race and Hispanic or Latino origin, for the United States, Regions, divisions, and states, and for Puerto Rico. 2000. Washing­ ton, DC: U.S. Census Bureau, 200lf.

U.S. Census Bureau. Table 4: Difference in population by race and Hispanic or Latino origin, for the United States. 1990 to 2000. *Census 2000: PHC-T-1* Washington, DC:

U.S. Census Bureau, 2001g.

U.S. Census Bureau. DP-2: Profile of selected social characteristics. 2000. Census 2000 Summary File 3 (SF-3) Sample data. United States. Washington, DC: U.S. Census Bu­ reau, 2002.

U.S. Census Bureau. Table 8. Foreign-born population by sex, citizenship status, and year of entry, for Asian alone and White alone, not Hispanic: March 2004. Current Population Survey, 2004 2004.

U.S. Census Bureau. *The American Commu­ nity-Asians: 2004.* U.S. Department of Commerce, U.S. Census Bureau 2007a.

U.S. Census Bureau. *The American Commu­ nity-Hispanics: 2004.* American Commu­ nity Survey Reports Washington, DC: U.S. Census Bureau, 2007b.

U.S. Census Bureau. U.S. Hispanic Population Surpasses 45 Million Now 15 Percent of To­ tal. *U.S. Census Bureau News* May 1, 2008 Washington, DC: U.S. Census Bureau, 2008.

U.S. Department of Agriculture, Economic Re­ search Service. Rural population and migra­ tion. *ERS/USDA Briefing Room* Washington, DC: U.S. Department of Agriculture, 2007.

U.S. Department of Health and Human Ser­ vices. Center for Substance Abuse Treatment comprehensive treatment model for alcohol and other drug abusing women and their children. *Blending Perspectives and Build­ ing Common Ground: A Report to Congress on Substance Abuse and Child Protection:* Appendix B. Washington, D.C.: U.S. Gov­ ernment Printing Office, 1999.

U.S. Department of Health and Human Services

- Office on Women's Health. *Eating Disor­ ders.* Washington, DC, 2000.

U.S. Department of Health and Human Ser­ vices - Office for Civil Rights. *Standards of Privacy for Individually Identifiable Health Information: Unofficial Version, 45 CFR Parts 160 and 164.* Washington, DC: U.S. Department of Health and Human Services, Office for Civil Rights, 2002.

U.S. Department of Health and Human Ser­ vices, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, and Prepared by Synetics for Man­ agement Decisions Incorporated. *Treatment Episode Data Set (TEDS), 2006.* Ann Arbor, MI: Consortium for Political and Social Re­ search, 2008a.

U.S. Department of Health and Human Ser­ vices, Substance Ahuse and Mental Health Services Administration, and Office of Ap­ plied Studies. *Treatment Episode Data Set (TEDS), 2006* [ Computer file]. Prepared by Synectics for Management Decisions, Incor­ porated. ICPSR21540-V2 Ann Arbor, Ml: Inter-university Consortium for Political and Social Research [producer and distributor], 2008-05-07, 2008b.

U.S. Department of Health and Human Ser­ vices, and Office of Women's Health. De­ pression during and after pregnancy, 2009. <http://www.womenshealth.gov/faq/depres>

U.S. Department of Health and Human Ser­ vices, National Institute on Drug Abuse, and Center for Substance Abuse Treatment. *DRAFT---CSATs Comprehensive Substance Abuse Treatment Model for Women and Their Children.* Unpublished manuscript.

U.S. Department of Housing and Urban Devel­ opment. The annual homeless assessment report to Congress. Washington, DC: U.S. Department of Housing and Urban Develop­ ment, 2007.

U.S. Department of Housing and Urban Devel­ opment. The second annual homeless assess­ ment report to Congress. Washington, DC: Office of Community Planning and Develop­ ment, 2008.

U.S. Department of Labor. *Women in the Labor Force: A Databook.* 2006. Available on-line: [http://www.bls.gov/cps/wlf-databook-2006.](http://www.bls.gov/cps/wlf-databook-2006) pdf

U.S. Preventive Services Task Force. Screen­ ing for depression: Recommendations and rationale. *Annals of Internal Medicine* 136(10):760-764, 2002.

van der Kolk, B.A., McFarlane, A.C., and Van der Hart, 0. A general approach to treat­ ment of posttraumatic stress disorder. In: van der Kolk, B.A., McFarlane, A.C., and Weisaeth, L., eds. *Traumatic Stress: The Ef­ fects of Overwhelming Experience on Mind, Body, and Society.* New York: Guilford Press, 1996. pp. 417-440.

van Etten, M.L., and Anthony, J.C. Male­ female differences in transitions from first drug opportunity to first use: Searching for subgroup variation by age, race, region, and urban status. *Journal of Womens Health* & *Gender-Based Medicine* 10(8):797-804, 2001.

van Etten, M.L., and Neumark, Y.D. Male-fe­ male differences in the earliest stages of drug involvement. *Addiction* 94(9):1413-1419,

1999.

Van Gundy, K. Substance abuse in rural and small town America. *Reports on Rural America Volume l, Number 2* Durham, New Hampshire: Carsey Institute, 2006.

Van Thiel, D.H., Gavaler, J.S., Rosenblum, E., and Tarter, R.E. Ethanol, its metabo­

lism and hepatotoxicity as well as its gonadal effects: Effects of sex. *Pharmacology and Therapeutics* 41(1-2):27-48, 1989.

van Wormer, K., and Askew, E. Substance­ abusing women and eating disorders. **In:** Straussner, S.L.A., and Zelvin, E., eds. *Gender and Addictions: Men and Women in Treatment.* Northvale, NJ: Jason Aronson, 1997. pp. 243-262.

VanDeMark, N.R., Russell, L.A., O'Keefe, M., Finkelstein, N., Noether, C.D., and Gam­ pel, J.C. Children of mothers with histories of substance abuse, mental illness, and trauma. *Journal of Community Psychology* 33(4):445-459, 2005.

Vannicelli, M. Treatment outcome of alcoholic women: The state of the art **in** relation to sex bias and expectancy effects. In: Wilsnack, S.C., and Beckman, L., eds. *Alcohol Prob­ lems in Women: Antecedents, Consequences, and Intervention.* New York: Guilford, 1984. pp. 369-412.

VanZile-Tamsen, C., Testa, M., Harlow, L.L., and Livingston, J.A. A measurement model of women's behavioral risk taking. *Health Psychology* 25(2):249-254, 2006.

Varan, L.R., Gillieson, M.S., Skene, D.S., and Sarwer-Foner, G.J. ECTin an acutely psy­ chotic pregnant woman with actively aggres­ sive (homicidal) impulses. *Canadian Journal of Psychiatry* 30(5):363-367, 1985.

Vega, W.A., Alderete, E., Kolody, B., and Aguilar-Gaxiola, S. Illicit drug use among Mexicans and Mexican Americans in Califor­ nia: The effects of gender and acculturation. *Addiction* 93(12):1839-1850, 1998.

Vega, W.A., Sribney, W.M., and Achara-Abra­ hams, I. Co-Occurring alcohol, drug and other psychiatric disorders among Mexican­ Origin people in the United States. *American Journal of Public Health* 93(7):1057-1064, 2003.

Velez, M.L., Jansson, L.M., Montoya, I.D., Schweitzer, W., Golden, A., and Svikis, D. Parenting knowledge among substance abus­ ing women in treatment. *Journal of Sub­ stance Abuse Treatment* 27(3):215-222, 2004.

Velez, M.L., Montoya, I.D., Jansson, L.M.,

Walters, V., Svikis, D., Jones, **H.E.,** Chilcoat, **H.,** and Campbell, J. Exposure to violence among substance-dependent preg­ nant women and their children. *Journal of Substance Abuse Treatment* 30(1):31-38, 2006.

Vernon, I., and Jumper Thurman, P. The changing face of HIV/AIDS among native populations. *Journal of Psychoactive Drugs* 37(3):247-255, 2005.

Vernon, I.S. American Indian women, HIV/ AIDS, and health disparity. *Substance Use* & *Misuse* 42(4):741-752, 2007.

Visscher, W.A., Feder, M., Burns, A.M., Brady, T.M., and Bray, R.M. The impact of smoking and other substance use by urban women on the birthweight of their infants. *Substance Use* & *Misuse* 38(8):1063-1093, 2003.

Vogel, L.C., and Marshall, L.L. PTSD symp­ toms and partner abuse: low income wom­ en at risk. *Journal of Traumatic Stress* 14(3):569-584, 2001.

Volk, R.J., Steinbauer, J.R., andCantor, SB. Patient factors influencing variation in the use of preventive interventions for alcohol abuse by primary care physicians. *Journal of Studies on Alcohol* 57(2):203-209, 1996.

Volkman, S. Music therapy and the treatment of trauma-induced dissociative disorders. *Arts in Psychotherapy* 20(3):243-251, 1993.

Volpicelli, J.R., Markman, I., Monterosso, J., Filing, J., and O'Brien, C.P. Psychosocially enhanced treatment for cocaine-dependent mothers: Evidence of efficacy. *Journal of Substance Abuse Treatment* 18(1):41-49, 2000.

Wagner, C.L., Katikaneni, L.D., Cox, T.H., and Ryan, R.M. The impact of prenatal drug exposure on the neonate. *Obstetrics and Gynecology Clinics of North America* 25(1):169-194, 1998.

Wakabayashi, C., and Donato, **K.M.** Does caregiving increase poverty among women in later life? Evidence from the health and

retirement survey. *Journal of Health and So­ cial Behavior* 47(3):258-274, 2006.

Wakschlag, L.S., Leventhal, B.L., Pine, D.S., Pickett, K.E., and Carter, A.S. Elucidating early mechanisms of developmental psycho­ pathology: the case of prenatal smoking and disruptive behavior. *Child Development* 77(4):893-906, 2006.

Wakschlag, L.S., Pickett, K.E., Cook E Jr, Be­ nowitz, N.L., and Leventhal, B.L. Maternal smoking during pregnancy and severe anti­ social behavior in offspring: a review. *Ameri­ can Journal of Public Health* 92(6):966-974, 2002.

Walitzer, K.S., and Dearing, R.L. Gender dif­ ferences in alcohol and substance use re­ lapse. *Clinical Psychology Review* 26(2):128- 148, 2006.

Wallace, B.C. Crack cocaine smokers as adult children of alcoholics: The dysfunctional family link. *Journal of Substance Abuse Treatment* 7(2):89-100, 1990.

Walton-Moss, B., and McCaul, M.E. Factors associated with lifetime history of drug treat­ ment among substance dependent women.

*Addictive Behaviors* 31(2):246-253, 2006.

Wampold, B.E. *The Great Psychotherapy Debate: Models, Methods, and Findings.* Mahwah, NJ: Lawrence Erlbaum Associates, Publishers, 2001.

Wang, J., and Patten, S.B. Prospective study of frequent heavy alcohol use and the risk of major depression in the Canadian gen­ eral population. *Depression and Anxiety* 15(1):42-45, 2002.

Warren, M., Frost-Pineda, **K.,** and Gold, M. Body mass index and marijuana use. *Journal of Addictive Diseases* 24(3):95-100, 2005.

Washington, O.G., and Moxley, D.P. Group interventions with low-income African American women recovering from chemi­ cal dependency. *Health and Social Work* 28(2):146-156, 2003.

Waterson, E.J., andMurray-Lyon, I.M. Are the CAGE question outdated? *British Journal of Addiction* 83(9):1113-1115, 1988.

Waxman, B.F. Hatred: The unacknowledged di­ mension in violence against disabled people. *Sexuality and Disability* 9(3):185-199, 1991.

Wayment, H.A., and Peplau, L.A. Social support and well-being among lesbian and heterosexual women: A structural modeling approach. *Personality* & *Social Psychology Bulletin* 21(11):1189-1199, 1995.

Weathers, F.W., Litz, B.T., Herman, D.S., Huska, J.A., and Keane, T.M. *The PTSD Checklist: Reliability, Validity,* & *Diagnos­ tic Utility. Paper presented at the Annual Meeting of the International Society for Traumatic Stress Studies,* San Antonio, TX, October. 1993.

Weatherspoon, A.J., Park, J.Y., and Johnson,

R.C. A family study of homeland Korean alcohol use. *Addictive Behaviors* 26(1):101- 113, 2001.

Webster, J., Linnane, J.W., Dibley, L.M., and Pritchard, M. Improving antenatal recogni­ tion of women at risk for postnatal depres­ sion. *Australian and New Zealand Journal of Obstetrics and Gynaecology* 40(4):409- 412, 2000.

Wechsberg, W.M., Zule, W.A., Riehman, K.S., Luseno, W.K., and Lam, W.K. African­ American crack abusers and drug treatment initiation: Barriers and effects of a pretreat­ ment intervention. *Substance Abuse Treat­ ment, Prevention and Policy* 2:10, 2007.

Weiderpass, E., Ye, W., Tamimi, R., Trichopolous, D., Nyren, 0., Vainio, H., and Adami, H.O. Alcoholism and risk for cancer of the cervix uteri, vagina, and vulva. *Can­ cer Epidemiology, Biomarkers and Preven­ tion* 10(8):899-901, 2001.

Weir, B.W., Stark, M.J., Fleming, D.W., He, H., and Tesselaar, H. Revealing drug use to prenatal providers: Who tells or who is asked? In: Stevens, S.J., and Wexler, H.K., eds. *Women and Substance Abuse: Gender Transparency.* New York: Haworth Press, 1998. pp. 161-176.

Weisner, C., Delucchi, K., Matzger, H., and Schmidt, L. The role of community services and informal support on five-year drinking trajectories of alcohol dependent and prob­ lem drinkers. *Journal of Studies on Alcohol* 64(6):862-873, 2003a.

Weisner, C., Matzger, H., and Kaskutas, L.A. How important is treatment? One-year outcomes of treated and untreated alcohol­ dependent individuals. *Addiction* 98(7):901- 911, 2003b.

Weisner, C., Mertens, **J., Tam,** T., and Moore,

C. Factors affecting the initiation of sub­ stance abuse treatment in managed care. *Addiction* 96(5):705-716, 2001.

Weiss, R.D., Martinez-Raga, J., Griffin, M.L., Greenfield, S.F., and Hufford, C. Gender differences in cocaine dependent patients: A 6 month follow-up study. *Drug and Alcohol Dependence* 44(1):35-40, 1997.

Welch, S.S. A review of the literature on the epidemiology of parasuicide in the general population. *Psychiatric Services* 52(3):368- 375, 2001.

Welle, D., Falkin, G.P., and Jainchill, N. Current approaches to drug treatment for women offenders: Project WORTH, Wom­ en's Options for Recovery, Treatment, and Health. *Journal of Substance Abuse Treat­ ment* 15(2):151-163, 1998.

Wellisch, J., Prendergast, M.L., and Anglin,

M.D. Needs assessment and services for

drug-abusing women offenders: Results from a national survey of community-based treat­ ment programs. *Women and Criminal Justice* 8(1):27-60, 1996.

West, C., and Zimmerman, **D.H.** Doing gender.

*Gender and Society* 1:125-151, 1987.

Wetter, **D.W.,** Fiore, M.C., Jorenby, D.E., Kenford, S.L., Smith, S.S., and Baker, **T.B.** Gender differences **in** smoking cessation.

*Journal of Consulting and Clinical Psychol­ ogy* 67(4):555-562, 1999.

Wexler, **H.K.,** Cuadrado, M., and Stevens, S.J. Residential treatment for women: Behavioral and psychological outcomes. In: Stevens, S.J., andWexler, H.K., eds. *Women and Substance Abuse: Gender Transparency.*

New York: Haworth Press, 1998. pp. 213- 233.

White, W.L. Recovery across the life cycle from alcohol/other drug problems: Pathways, styles, developmental stages. *Alcoholism Treatment Quarterly* 24(1-2):185-201, 2006.

White, W.L., and Whiters, D.L. Faith-based recovery: Its historical roots. *Counselor Magazine* 6(5):58-62, 2005.

Wilcox, S., Evenson, **K.R.,** Aragaki, A., Wassertheil-Smoller, S., Mouton, C.P., and Loevinger, B.L. The effects of widowhood on physical and mental health, health be­ haviors, and health outcomes: The Wom­ en's Health Initiative. *Health Psychology* 22(5):513-522, 2003.

Wilkins, A. Substance Abuse and TANF. *Wel­ fare Reform:* 1-12. Denver, CO: National Conference of State Legislators 2003.

Williams, D.R. Race and health: Basic ques­ tions, emerging directions. *Annals of Epide­ miology* 7(5):322-333, 1997.

Williams, D. R. Racial/ethnic variations in women's health: the social embeddedness of health. *American Journal of Public Health,* 92,588-597,2002.

Wilsnack, R.W., and Cheloha, R. Women's roles and problem drinking across the lifespan. *Social Problems* 34(3):231-248, 1987.

Wilsnack, R.W., Wilsnack, S.C., Kristjanson, A.F., and Harris, T.B. Ten-year prediction of women's drinking behavior in a nation­ ally representative sample. *Womens Health* 4(3):199-230, 1998a.

Wilsnack, R.W., Wilsnack, S.C., Kristjanson, A.F., Harris, T.R., and Vogeltanz, N.D. *"Drinking in couples: How is partners' con­ sumption connected?"* Paper presented at the Annual Scientific Meeting of the Research Society on Alcoholism, Hilton Head, SC, June, 1998b.

Wilsnack, S.C. Barriers to treatment for al­ coholic women. *Addiction and Recovery* 11(4):10-12, 1991.

Wilson, **D.J.** Drug Use, Testing, and Treatment in Jails. Washington, DC: Bureau of Justice Statistics 2000.

Wilt, S., and Olson, S. Prevalence of domestic violence in the United States. *Journal of the American Medical Womens Association* 51(3):77-82, 1996.

Winhusen, T., Kropp, F., Babcock, D., Hague, D., Erickson, S.J., Renz, C., Rau, L., Lewis, D., Leimberger, J., and Somoza, E. Moti­ vational enhancement therapy to improve treatment utilization and outcome in preg­ nant substance users. *Journal of Substance Abuse Treatment* 2007.

Winslow, B.T., Voorhees, K.I., and Pehl, K.A. Methamphetamine abuse. *American Family Physician* 76(8):1169-1174, 2007.

Winters, J., Fals-Stewart, W., O'Farrell, T.J., Birchler, G.R., and Kelley, M.L. Behavioral couples therapy for female substance-abus­ ing patients: Effects on substance use and relationship adjustment. *Journal of Consult­ ing and Clinical Psychology* 70(2):344-355, 2002.

Wise, L., and Correia, A. A review of nonphar­ macologic and pharmacologic therapies for smoking cessation. (cover story). *Formulary* 43(2):44-64, 2008.

Wobie, K., Eyler, F.D., Conlon, M., Clarke, L., and Behnke, M. Women and children in residential treatment: Outcomes for moth­ ers and their infants. *Journal of Drug Issues* 27(3):585-606, 1997.

Wolpe, **J.** *The practice of behavior therapy.* 1st ed. ed. New York: Pergamon Press, 1969.

Wright, **N.M.,** Tompkins, C.N., and Sheard, L. Is peer injecting a form of intimate partner abuse? A qualitative study of the experiences of women drug users. *Health* & *Social Care in the Community* 15(5):417--425, 2007.

Young, A.M., and Boyd, C. Sexual trauma, substance abuse, and treatment success in a sample of African American women who smoke crack cocaine. *Substance Abuse* 21(1):9-19, 2000.

Young, **N.K.,** and Gardner, S.L. *Implementing Welfare Reform: Solutions to the Substance Abuse Problem.* Irvine, CA: Children and Family Futures, 1997.

Young, **N.K.,** Gardner, S.L., and Dennis, **K.** *Responding to Alcohol and Other Drug Problems in Child Welfare: Weaving To­ gether Practice and Policy.* Washington, DC: Child Welfare League of America, 1998.

Young, **R.M.,** Friedman, S.R., and Case, P. Exploring an HIV paradox: an ethnography of sexual minority women injectors. *Jonrnal of Lesbian Stndies.* 9(3):103-116, 2005.

Zambrana, R.E., Ell, K., Dorrington, C., Wachsman, L., and Hodge, D. The relation­ ship between psychosocial status of immi­ grant Latino mothers and use of emergency pediatric services. *Health and Social Work* 19(2):93-102, 1994.

Zanis, D.A., McLellan, A.T., Cnaan, R.A., and Randall, M. Reliability and validity of the Addiction Severity Index with a homeless sample. *Jonrnal of Substance Abuse Treat­ ment* 11(6):541-548, 1994.

Zerbe, **K.J.** *The Body Betrayed: Women, Eat­ ing Disorders, and Treatment.* Washington, DC: American Psychiatric Press, 1993.

Zhang, **S.M.,** Lee, **I.M.,** Manson, **J.E.,** Cook, N.R., Willett, W.C., and Buring, J.E. Alco­ hol consumption and breast cancer risk in the Women's Health Study. *American Jonr­ nal of Epidemiology* 165(6):667-676, 2007.

Zilberman, M.L., Tavares, H., Andrade, A.G., and el-Guebaly, N. The impact of an outpa­ tient program for women with substance use­ related disorders on retention. *Substance Use and Misnse* 38(14):2109-2124, 2003.

Zilm, D.H., and Sellers, E.M. The quantita­ tive assessment of physical dependence on opiates. *Drug and Alcohol Dependence* 3(6):419--428, 1978.

Zlotnick, C., Franchino, K., St Claire, N., Cox, K., and St John, M. The impact of outpatient drug services on abstinence among pregnant and parenting women. *Journal of Snbstance Abnse Treatment* 13(3):195-202, 1996.

Zlotnick, C., Najavits, L.M., Rohsenow, D.J., and Johnson, D.M. A cognitive-behavioral treatment for incarcerated women with substance abuse disorder and posttraumatic stress disorder: findings from a pilot study. *Journal of Substance Abnse Treatment* 25(2):99-105, 2003.

Zolopa, A.R., Hahn, J.A., Gorter, R., Miranda, J., Wlodarczyk, D., Peterson, J., Pilote,

L., and Moss, A.R. HIV and tuberculosis infection in San Francisco's homeless adults. Prevalence and risk factors in a represen­ tative sample. *JAMA: The Journal of the American Medical Association* 272(6):455- 461, 1994.

Zuckerman, B., Frank, D., and Brown, E. Overview of the effects of abuse and drugs on pregnancy and offspring. In: Chiang, C.N., and Finnegan, L.P., eds. *Medications Development for the Treatment of Pregnant Addicts and Their Infants.* NIDA Research Monograph 149. NIH Publication No. 95- 3891. Rockville, MD: National Institute on Drug Abuse, 1995. pp. 16-38.

Zule, W.A., Flannery, B.A., Wechsberg, W.M., and Lam, **W.K.** Alcohol use among out-of­ treatment crack using African -American women. *American Journal of Drug* & *Alco­ hol Abnse* 28(3):525, 2002.

Zule, W.A., Lam, W.K., and Wechsberg, W.M. Treatment readiness among out-of-treatment African-American crack users. *Journal of Psychoactive Drugs* 35(4):503-510, 2003.

Zweben, J.E. Psychiatric problems among alcohol and other drug dependent women. *Journal of Psychoactive Drugs* 28(4):345- 366, 1996.

Zywiak, **W.H.,** Stout, R.L., Trefry, W.B., Glasser, I., Connors, G.J., Maisto, S.A., and Westerberg, V.S. Alcohol relapse repetition, gender, and predictive validity. *Jonrnal of Substance Abnse Treatment* 30(4):349-353, 2006.