

Substance Abuse Treatment: Addressing the Specific Needs of Women

A Treatment Improvement Protocol TIP 51



Substance Abuse and Mental Health Services Administration

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A Treatment Improvement Protocol

TIP 51

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Substance Abuse and Mental Health Services Administration

1 Choke Cherry Road
Rockville, MD 20857

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Contents

What Is a TIP?	vii
Consensus Panel	ix
Editorial Board	xi
KAP Expert Panel and Federal Government Participants	xiii
Foreword	xv
Executive Summary	xvii
Chapter 1—Creating the Context	1
Overview.....	1
Creating the Context	1
Gender Responsive Treatment Principles	4
Women’s Biopsychosocial Uniqueness.....	6
Organization of This TIP	15
Chapter 2—Patterns of Use: From Initiation to Treatment	17
Overview.....	17
Initiation of Use Among Women	18
Risk Factors Associated with Initiation of Substance Use and the Development of Substance Use Disorders Among Women	18
Patterns and Prevalence of Substance Use Among Women.....	26
Prevalence of Substance Abuse and Dependence Among Women	30
Chapter 3—Physiological Effects of Alcohol, Drugs, and Tobacco on Women	37
Overview.....	37
Physiological Effects and Consequences of Substance Abuse In Women	38
Physiological Effects: Factors of Influence	38
Physiological Effects of Alcohol	40
Physiological Effects of Licit and Illicit Drugs.....	46
Physiological Effects of Tobacco Use	48
Effects of Alcohol, Drugs, and Tobacco Use on Pregnancy and Birth Outcomes	48
Effects of Alcohol and Illicit Drugs on HIV/AIDS Status.....	52
Chapter 4—Screening and Assessment	57
Overview.....	57
The Difference Between Screening and Assessment	58
Screening and Assessment: Factors of Influence	58

Screening	60
Assessment	74
Chapter 5—Treatment Engagement, Placement, and Planning.....	83
Overview.....	83
Barriers to Treatment Engagement	83
Treatment Engagement Strategies.....	87
Considerations in Treatment Placement and Planning	92
Levels of Care	92
Chapter 6—Substance Abuse Among Specific Population Groups and Settings	103
Overview.....	103
Racially and Ethnically Diverse Women	104
Sexual Orientation and Women.....	123
Women Later in Life	127
Women in Rural America	130
Resources for Other Special Populations and Settings	133
Women in the Criminal Justice System.....	134
Women Who Are Homeless	135
Chapter 7—Substance Abuse Treatment for Women	137
Overview.....	137
Treatment Retention	137
Women’s Treatment Issues and Needs.....	143
Addressing Tobacco Use with Women in Treatment.....	177
Chapter 8—Recovery Management and Administrative Considerations	181
Overview.....	181
Continuing Care	181
Treatment Outcome	182
Support Systems for Women	186
Administrative Considerations.....	187
Appendix A: Bibliography.....	197
Appendix B: CSAT’s Comprehensive Substance Abuse Treatment Model for Women and Their Children	273
Appendix C: Screening and Assessment Instruments.....	297
Appendix D: Allen Barriers to Treatment Instrument.....	307
Appendix E: DSM-IV-TR Criteria for Posttraumatic Stress Disorder	311
Appendix F: Integration Self-Assessment for Providers.....	313
Appendix G: Resource Panel Members.....	319
Appendix H: Cultural Competency and Diversity Network Participants.....	323
Appendix I: Field Reviewers.....	325
Appendix J: Acknowledgments.....	333
Index	335

Figures

1-1	A Woman's Life in Context	3
1-2	Interrelated Elements in the Comprehensive Treatment Model	4
2-1	Use of Illicit Drugs, Alcohol, or Tobacco by Females Aged 12 or Older, Past Year and Past Month, Numbers in Thousands and Percentages, 2006	29
2-2	Past Month Substance Use, Based on Combined 2006 and 2007 Data: National Survey on Drug Use and Health (NSDUH).....	30
2-3	Percentages of Past-Year Abuse of or Dependence on Alcohol or Any Illicit Drug by Gender and Age, 2006	31
2-4	Percentages of Past-Year Abuse of or Dependence on Alcohol or Any Illicit Drug Among Women Aged 18 or Older by Age Group: 2003	32
2-5	Percentage of Admissions to Substance Abuse Treatment Programs by Racial/Ethnic Group in 2006	33
2-6	Primary Substance of Abuse Among Women Admitted for Substance Abuse Treatment by Racial/Ethnic Group by Percentage.	34
4-1	The CAGE Questionnaire.....	62
4-2	The TWEAK Questionnaire: Women.....	64
4-3	The T-ACE Questionnaire	64
4-4	5Ps Screening	65
4-5	Questions to Screen for Trauma History	69
4-6	Questions Regarding Sexual Abuse.	71
4-7	STaT: Intimate Partner Violence Screening Tool	72
4-8	General and Specific Screening Questions for Persons with Possible Eating Disorders	73
4-9	Available Screening and Assessment Tools in Multiple Languages	80
5-1	Percentages of Reasons for Not Receiving Substance Use Treatment in the Past Year Among Women Aged 18–49 Who Needed Treatment and Who Perceived a Need for It: 2004–2006	85
5-2	PROTOTYPES	91
5-3	Services Needed in Women's Substance Abuse Treatment	93
6-1	Group Therapy: Promising Practices and Strategies for African-American Women.....	113
7-1	Violence and Women	156
7-2	PTSD Symptoms.....	162
7-3	Helpful Skills for Trauma Victims	163
7-4	Common Definitions of Eating Disorders and Behaviors.....	175
8-1	Women-Specific Predictors of Relapse and Reactions to Relapse	184
8-2	Women's Recovery Group: Manual-Based Relapse Prevention	185
8-3	Goals and Training Guidelines for Point-of-Entry Staff (Non-Substance-Abuse Treatment Providers).....	190
8-4	Goals and Training Guidelines for Substance Abuse Treatment Counselors.....	191
8-5	State Standard Examples of Gender-Specific Treatment.....	195
B-1	Interrelated Elements in the Comprehensive Treatment Model	276
B-2	Elements of Clinical Treatment Services.....	277
B-3	Elements of Clinical Support Services	279

B-4	Elements of Community Support Services	280
B-5	Clinical Treatment Services for Children.....	281
B-6	Clinical Support Services for Children	282
B-7	Interrelated Elements of Clinical Treatment and Support Services for Women and Their Children	284
Advice to the Clinician and Administrator Boxes		
<i>Chapter 2</i>		
	Using Patterns of Use as a Clinical Guide	35
<i>Chapter 3</i>		
	Substance Use and Birth Outcomes.....	50
<i>Chapter 4</i>		
	Culturally Responsive Screening and Assessment	59
	Substance Abuse Screening and Assessment Among Women	61
	At-Risk Screening for Drug and Alcohol Use During Pregnancy	66
	Mental Health Screening and Women	75
	General Guidelines for Selecting and Using Screening and Assessment Tools	76
	General Guidelines of Assessment for Women	81
<i>Chapter 5</i>		
	The Impact of Trauma and Prenatal Care	102
<i>Chapter 6</i>		
	Substance Abuse Treatment and Hispanic/Latina Women.....	106
	Substance Abuse Treatment and African-American Women	114
	Substance Abuse Treatment and Asian- and Pacific-American Women.....	116
	Substance Abuse Treatment and Native-American Women.....	121
	Substance Abuse Treatment and Lesbian and Bisexual Women	125
	Substance Abuse Treatment and Older Women	129
	Substance Abuse Treatment and Women in Rural Areas	132
<i>Chapter 7</i>		
	Relational Model Approach	144
	Considerations in Involving the Partner in Treatment	146
	Women with Co-Occurring Disorders	158
	When is a Woman Ready for Trauma Processing?	167
	Retraumatization	169
	Women With Eating Disorders	177
<i>Chapter 8</i>		
	Postpartum Relapse Prevention.....	186

What Is a TIP?

Treatment Improvement Protocols (TIPs) are developed by the Center for Substance Abuse Treatment (CSAT), part of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (HHS). Each TIP involves the development of topic-specific best-practice guidelines for the prevention and treatment of substance use and mental disorders. TIPs draw on the experience and knowledge of clinical, research, and administrative experts of various forms of treatment and prevention. TIPs are distributed to facilities and individuals across the country. Published TIPs can be accessed via the Internet at <http://store.samhsa.gov>.

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

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Foreword

The Treatment Improvement Protocol (TIP) series fulfills the Substance Abuse and Mental Health Services Administration's (SAMHSA's) mission to improve prevention and treatment of substance use and mental disorders by providing best practices guidance to clinicians, program administrators, and payers. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates debates and discusses their particular area of expertise until they reach a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

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

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6 Substance Abuse Among Specific Population Groups and Settings

In This Chapter

Racially and
Ethnically Diverse
Women

Sexual Orientation
and Women

Women in Later Life

Women in Rural
America

Resources for Other
Special Populations
and Settings

Overview

Gender-appropriate and culturally responsive health care improves both short- and long-term outcomes, not just for women with substance use disorders but also for clients with almost any type of healthcare problem. The likelihood of good health or the prevalence of certain disorders is, in part, a product of gender. Certain health issues are unique to women; others affect women disproportionately compared to men; and still others have a different effect on women than on men. To add to these gender differences, the National Institutes of Health (NIH) has identified critical racial and ethnic disparities in health that result in different outcomes or consequences in some groups. Other factors such as sexual orientation also have been shown to affect health status (Dean et al. 2000).

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

This chapter provides an overview of available substance-related research for women in specific racial and ethnic groups, settings, and special populations in the United States across four domains: demographics, substance abuse patterns, clinical treatment issues, and resiliency factors. It highlights the need for cultural competence in the delivery of substance abuse treatment and suggests specific and culturally congruent clinical, programmatic, and administrative strategies. For more detailed information on substance related

disorders and substance abuse treatment across racially and ethnically diverse populations; the influence of culture on substance abuse patterns, help-seeking behavior, and health beliefs; and guidelines for culturally congruent and competent treatment services, see the planned TIP *Improving Cultural Competence in Substance Abuse Treatment* (Center for Substance Abuse Treatment [CSAT] in development a).

Main sections of this chapter address clinical issues related to treating women of different racial and ethnic groups, women of different sexual orientations, older women, and women living in rural areas. Although certain elements of their substance use disorders are common to all these groups (such as trauma and/or socioeconomic stresses), each group also has unique features that will further influence their engagement and successful completion of treatment (including cultural values, beliefs about health care, and help-seeking behavior). Each group of women also brings a unique capacity for resiliency and recovery, and these factors are explored as well. The chapter concludes with a brief review of special populations and settings—women with disabilities, women in the criminal justice system, and women who are homeless.

Racially and Ethnically Diverse Women

Hispanic/Latina Women

Demographics

Of the approximately 40 million Hispanic/Latino people living in the United States and its Territories, Mexican Americans are the largest group (64 percent), followed by Puerto Ricans (10 percent), Central and South Americans (13 percent), Cubans (4 percent), and other Hispanics or Latinos (9 percent) (U.S. Census Bureau 2007). Half the U.S. Hispanic/Latino population is concentrated in California and Texas. An additional 23 percent reside in Florida, Illinois, New Jersey, Arizona, and New

York (U.S. Census Bureau 2007). Women of Hispanic origin in the United States numbered 17 million or slightly less than half the total U.S. Hispanic population (U.S. Census Bureau 2001d).

The Hispanic/Latino population is a young, rapidly growing ethnic and cultural group in the United States. At 14 percent of the population, Hispanics/Latinos currently are the largest ethnic subpopulation (U.S. Census Bureau 2007). The recent population growth of Hispanics/Latinos is mainly due to the relative youth and high birth rates of this population (Bachu and O'Connell 2001) and, in part, to immigration. Yet, most Hispanics/Latinos are born in the U.S. and are not immigrants (U.S. Census Bureau 2007). By 2050, Hispanics/Latinos are expected to nearly triple in number (U.S. Census Bureau 2000b).

The socioeconomic status of the U.S. Hispanic/Latino population may reflect the circumstances of immigration; that is, those who immigrated for economic reasons (the vast majority) tend to be poorer, less well educated, and younger than the overall population. More than a quarter of all Hispanics/Latinos lack health insurance coverage for more than 1 year (Cohen et al. 2004). Approximately 40 percent of Hispanic/Latino families headed by women live in poverty (U.S. Census Bureau 2007), and many of these women are likely to face the combined stresses of poverty, lack of health insurance, and lack of health care (U.S. Census Bureau 2002).

Substance use among Hispanics/Latinas

Alcohol

Most research on substance abuse among Hispanics/Latinas has focused on alcohol (e.g., Ames and Mora 1988; Canino 1994; Gilbert 1991) and has confirmed the widely held belief that, regardless of national origin, Hispanics/Latinas generally have higher rates of abstinence from alcohol and drink alcohol less frequently than Hispanic/Latino men. In a survey of 764 Hispanic/Latino men and 817 Hispanic/Latina women of all ages, 33 percent of the

men reported frequent and/or heavy drinking, compared with 12 percent of the women. Conversely, 57 percent of the women versus 35 percent of the men reported that they abstained from alcohol use. Thirty-one percent of the women reported infrequent drinking (Aguirre-Molina et al. 2001). This phenomenon has been attributed to strict cultural sanctions against drinking by women that are typical throughout Latin America (Mora 1998) and are maintained by many Hispanics/Latinas in the United States.

Research indicates that some Hispanics/Latinas generally maintain the cultural norms of their countries of origin and resist social pressures to engage in substance use (Mora 2002). However, other research (e.g., Caetano 1988, 1989; Caetano et al. 2007) comparing substance abuse both by gender and within and across Hispanic/Latino subgroups suggests a far more complex relationship between Hispanics/Latinas and substance abuse (Mora 2002). For instance, Mexican-American women show higher rates of abstinence than Cuban and Puerto Rican women. However, they also exhibit the highest rates of frequent heavy drinking of all Hispanic/Latina subgroups (Caetano 1989; Mora 1998). Thus, Mexican-American women who consume any alcohol at all tend to drink frequently and heavily. Mora (1998) explains that this paradox originates from differences between immigrant Mexican women and their American-born counterparts. More established generations of U.S. Hispanics/Latinas—in particular young Mexican-American and Puerto Rican women—drink more alcohol than immigrant women of their subgroups. These differences in alcohol use among Hispanics/Latinas appear to depend primarily on age, generational status, level of acculturation, and country of origin (Collins and McNair 2002; Randolph et al. 1998).

Illicit drug use

The pattern of illicit drug use among Hispanics/Latinas is influenced by level of acculturation and country of origin. In one study based on the Hispanic Health and Nutrition Examination Survey (HHANES) data, illicit drug use among Hispanics/Latinas generally increased with acculturation (Amaro et al. 1990). The

2006 Treatment Episode Data Set (TEDS), a Substance Abuse and Mental Health Services Administration (SAMHSA) data set that provides information on treatment completion, length of treatment stay, and discharge demographics, indicated that Hispanic/Latina women admitted to substance abuse treatment were more likely to report opiates (19 percent) as their primary substance of abuse followed by cocaine/crack (18 percent), marijuana (14 percent), and methamphetamine. In addition, the primary substance of abuse varied according to Hispanic origin: Puerto Rican and Cuban-American women reported more opiate use, whereas Mexican-American women reported more methamphetamine use (SAMHSA 2008).

Sociodemographic factors associated with substance use and substance use disorders

Socioeconomic status, age, and length of time in the United States are associated with substance use and substance use disorders among Hispanic/Latina women. Among this population, those with the most notable risks for substance use disorders are women who immigrated to the U.S. at an earlier age (before 7 years of age) or who were born in the U.S. (Canino et al. 2008; Vega et al. 2003). Of particular concern, the 2007 Youth Risk Behavior Survey found a growing prevalence of alcohol and other drug use among adolescent Hispanic/Latina females (Eaton et al. 2008). Studies have also isolated employment, marital status, and educational level as predictors of alcohol consumption and substance use disorders among Hispanics/Latinas. In a study evaluating racial/ethnic differences among women with co-occurring mental and substance use disorders, Hispanic/Latina women possessed significant social vulnerability characterized by lower socioeconomic and educational status, exposure to violent crimes, and higher rates of criminal justice involvement (Amaro et al. 2005).

Gender socialization

In the Hispanic/Latina culture, women often are afforded special status and respect as matriarchs of extended family networks (Mora

Advice to Clinicians and Administrators

Substance Abuse Treatment and Hispanic/Latina Women

Clinical:

- Conduct initial assessment to determine the women's level of acculturation, development and identification of ethnic identity, and worldview (Baron 2000).
- Provide clients with opportunities to identify and express feelings about their heritage and self-perception.
- Encourage exploration of strengths in their cultural backgrounds, histories, and heritages, including opportunities to explore old and new ways to incorporate spirituality into their lives.
- Develop opportunities to build alliances and relationships with women (including staff and other clients) from other groups and cultures.

Program Development:

- Generate a program philosophy that supports personal growth and empowerment within a cultural and family context.
- Develop linkages with other community resources and case management to help with legal issues, education, job training, domestic violence, medical care, housing, and other support systems.
- Plan for interpreter services and develop access to bilingual providers.
- Adopt acculturation assessment tools that include information on migration patterns, acculturation level, experiences, stress, country of origin, and specific endorsement of Hispanic/Latina values.
- Develop and provide psychoeducational family programs.

Staff Training:

- Invest in culturally competent staff training that promotes an understanding of:
 - Common Hispanic/Latina cultural beliefs, worldview, customs, spirituality, and religion.
 - The possible relational needs of many Hispanics/Latinas.
 - The centrality of family and knowledge of approaches for incorporating family in treatment.
 - The immigration experience and effects of acculturative stress on many Hispanics/Latinas' roles, responsibilities, family life, substance abuse, and recovery.

Source: Alvarez and Ruiz 2001; Caetano et al. 2007; CSAT 2003b; and Medina 2001

2002). Some Hispanics/Latinas, especially those who are more acculturated, may deemphasize or reject these cultural expectations, but early childhood messages (e.g., the “proper role of a señorita”) may remain embedded in the cultural and personal identities of many in this group (Mora 1998). The stresses of negotiating and

integrating traditional cultural expectations with new cultural values may result in or exacerbate the prevalence of mental and substance use disorders for many Hispanics/Latinas; more research is needed on this subject (Gloria and Peregoy 1996; Mora 1998).

Acculturation

It has been suggested that acculturation, the process of adapting and adjusting to new surroundings while maintaining a cultural identity, more than any other factor, affects Hispanics/Latinas' substance abuse (Caetano 1989, 1994; Gilbert 1991; Keefe and Padilla 1987; Markides et al. 1988). The onset of alcohol and drug abuse among some Hispanics/Latinas may be explained by acculturative and environmental stresses (e.g., new roles, expectations, opportunities) that result in greater exposure to these substances (Gilbert 1991; Mora 1998). HHANES data study revealed that, for women of all ages in three major subgroups (Mexican American, Puerto Rican, and Cuban American), level of acculturation was correlated consistently with both increased frequency of consumption and increased probability of being a drinker at all (Black and Markides 1993).

Studies consistently have shown that acculturation is positively correlated with consumption of greater quantities of alcohol, greater frequency of alcohol use, and higher rates of drug abuse among Hispanics/Latinas (Amaro et al. 1990; Mora 1998). These findings have significant implications in providing substance abuse treatment, in that the role of acculturation and gender socialization should be a central theme in treatment planning. Specifically, Mora (1998) suggests that clinicians explore with Hispanic/Latina clients several key questions: How have their traditional roles changed since immigration or in comparison to their own mothers? How have these changes in roles influenced their substance use behavior? In what ways have educational and employment opportunities influenced or altered their substance use?

Clinical treatment issues

At first glance, the heterogeneity of Hispanics/Latinas in terms of language, values, and backgrounds may seem to challenge the creation of effective, culturally responsive treatment programs for Hispanic/Latina women. Programs committed to serving Hispanics/Latinas, however, can develop effective services

by endorsing culturally competent practices, such as culturally specific assessment tools, counseling that endorses the clients' worldviews, staff training to increase cultural awareness and knowledge, and programs that reflect and respect cultural values. For example, substance abuse treatment programs can create a treatment environment that honors cultural heritage and incorporates values such as *familismo* (reliance on and regard for family and family cohesiveness), when appropriate.

Some treatment issues reflect beliefs or traditions more specific to Hispanics/Latinas. A strong cultural prohibition exists against discussing family matters such as substance use or abuse during childhood, thus the use of psychoeducational groups to provide information on these topics may be more effective initially than therapy groups, where experiences are discussed openly. However, substance abuse counseling based on a family model often is well suited and is more culturally congruent for many Hispanics/Latinas. When engaging in family therapy, therapists need to enter the family relationship as a "learner," since Hispanic/Latino families are so diverse. Counselors need to take the time to understand each client's family history within a cultural context (Rotter and Casado 1998), including the initial identification of the country of origin and family members' acculturation history and levels. Counselors also need to embrace a more expansive definition of family that may include extended family members and others. Early on in treatment, counselors need to assess how the current substance-related problems affect the family's culture and how the culture affects the current presenting issues. Because the exalted role of motherhood in Hispanic/Latino culture often makes loss of child custody especially stigmatizing, treatment programs need to provide support for appropriate family reunification. On a more fundamental level, Hispanics/Latinas may benefit from assistance in gaining English language skills, in job training that leads to employment, in finding stable housing, and in negotiating the requirements for treatment entry (Amaro et al. 1999; Kail and Elberth 2002).

Another treatment concern expressed among some Hispanics/Latinas in treatment—particularly those who are highly acculturated or isolated from a larger Hispanic/Latino community—is alienation from their cultural heritage. It may be difficult to address cultural alienation in treatment because a client may be far removed from her cultural background. A therapeutic decision must be made whether a cultural framework for recovery and empowerment should be utilized for all clients or only for those who request or show interest in this approach. Cultural knowledge can be empowering for many women of color, but not for all; care should be taken to adopt this approach only for those who are comfortable with it.

Hispanics/Latinas represent 14 percent of all new HIV/AIDS cases among women (CDC 2007). Among Hispanic women, 65 percent acquired HIV/AIDS through high-risk heterosexual transmission and 33 percent were infected through injection drug use. Since Hispanic women represent the second largest ethnically diverse group of women living with HIV/AIDS at the end of 2005, education and other prevention services should be essential components of substance abuse treatment.

Similar to other population groups of women, Hispanics/Latinas with substance use disorders experience a high rate of co-occurring mental disorders (Amaro et al. 2005). These disorders also need to be identified and treated if substance abuse treatment is to lead to recovery. A study of 66 Hispanics/Latinas enrolled in a residential substance abuse treatment program found that most (80 percent) reported a childhood history of abuse, as well as mental health problems (76 percent) and physical health problems (68 percent) (Amaro et al.

1999). Compared with women who had not experienced childhood abuse, those with such a history experienced more severe health problems and were more likely both to lose custody of their children and to drop out of treatment. To treat these problems adequately, the relationship between a woman's abuse history and substance use or co-occurring mental disorders must be determined. See TIP 36 *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT 2000b) for more information.

Resiliency factors

The counselor should evaluate and adopt treatment approaches that are strength-based and that build on the resources and strengths of the client's culture, individual traits and experiences, spirituality, and family. Among Hispanic/Latina clients, families are typically an important part of the support network and can function as a resource in recovery. Similarly, the centrality of family ties may provide motivation for treatment and a sense of responsibility to family. In a study that evaluated the role of family in reducing or delaying alcohol use among young Hispanic/Latina females, services that help improve parental connections can have long-term positive effects (Sale et al. 2005).

In addition, culturally defined gender roles can also serve as a strength-based metaphor for the challenges that clients face as they begin their journeys in recovery. These gender roles, if properly acknowledged during treatment, can emphasize the most positive aspects of *marianismo* and *hembrismo* (the counterparts to *machismo*), such as “strength, perseverance, flexibility, and an ability to survive . . . [that can] . . . promote non-use while respecting

Based on the knowledge and experience gained from the Demonstration Grant Program for Residential Women and their Children (RWC) and the Services Grant Program for Residential Treatment for Pregnant and Postpartum Women (PPW), the publication *Lessons Learned: Residential Substance Abuse Treatment for Women and Their Children* (CSAT 2003b) was developed. Along with other important aspects of residential treatment for women and children, this report provides insight into how to integrate culturally congruent services among Hispanic/Latina women in residential substance abuse treatment.

“La Casita” (which means “the little house” in Spanish) is a residential chemical dependency treatment program designed to meet the needs of low-income Hispanic/Latina mothers. The treatment program places emphasis on the importance of family and its critical role in promoting therapeutic change. La Casita integrates culturally relevant strategies and Hispanic/Latina cultural values with other effective treatment approaches, such as, “simpatia” (the promotion of pleasant social relationships), “lineality” (importance of authority figures in the solution of problems), and “reciprocity” (giving back, in some way, what was given). By adapting these cultural values in treatment, women have an opportunity to use their ethnic heritage as a catalyst for recovery (CSAT 2003b).

and maintaining the role of the woman within the family” (Gloria and Peregoy 1996; p. 122). Similarly, religion and spiritual practices are very important for many traditional Hispanics/Latinas in the United States and may serve as a source of sustenance in recovery. Religious beliefs may involve a combination of traditional practices and rituals, world religions, and religious practices in and outside the structure of church (Altarriba and Bauer 1998).

African-American Women

Demographics

There are major differences in cultural identification, income, education, marital status, occupation, and lifestyle between African-American women born in the United States and foreign-born women of African descent (Gray and Littlefield 2002; NIH, ORWH 1999). While this section focuses primarily on African-American women born in the United States, further research is needed to identify intragroup variations in substance abuse etiology and effective treatments.

More than 32 million African Americans live in the United States, including sizable numbers of both African and African-Caribbean immigrants. It is a relatively young population: 32 percent of all African Americans are under age 18. More than half live in a central city within a metropolitan area. African Americans represent 12.3 percent of the U.S. population (U.S. Census Bureau 2001f). Nineteen million, or more than half, of all African Americans are females (U.S. Census Bureau 2001d). Among African-American women, poverty is more prevalent than in the general population (Gray

and Littlefield 2002). Among African-American single mothers, approximately 35 percent live in poverty compared to 19 percent of non-Hispanic single white mothers.

Although genetics account for differential rates of some diseases among African Americans (e.g., sickle cell anemia), biology alone explains very little about the disparities in health status between African Americans and Caucasians. Overall, African Americans have disproportionately higher rates of disease and illness, a wider variety of undetected diseases, more chronic health conditions, and shorter life expectancies than Caucasians. African-American women experience higher morbidity and mortality rates than do Caucasian women for many health conditions (Minino et al. 2002).

Substance use among African Americans

Even though the total substance abuse admissions among African Americans has been steadily declining since the 1990s, TEDS reports that 21 percent of admissions to substance abuse treatment facilities were African American in 2006 in comparison to 12 percent of non-Hispanic population (HHS 2008a). The primary source of referral to treatment among African-American women was through self-referral or by family and friends (SAMHSA 2004).

Alcohol

According to TEDS (HHS 2008a), alcohol accounted for 25 percent of substance abuse treatment admissions among African-American women. While most research highlights differences in alcohol use patterns between African-American women and men, and between

African-American women and other diverse groups of women, little attention is given in reporting on the diversity of use among African-American women within their cohort group and throughout their lifespan. In one study comparing differences in alcohol prevalence across age groups, ethnicity, and gender, prevalence rates among African-American females from 19 to 29 years of age rose from 2 percent to 4 percent between 1992 and 2002 (Grant et al. 2006). In a study evaluating the correlates of alcohol consumption of African-American women, women age 40 to 49 have shown the highest prevalence of alcohol consumption (Rosenberg et al. 2002).

Illicit drug use

Among African-American women, most admissions to treatment facilities were for cocaine/crack abuse (35 percent; HHS 2008a). From the same data set, opioids, primarily heroin, accounted for 18 percent of substance-related admissions. In a study that focused on severity of alcohol use and crack/cocaine, evidence suggests that as the level of alcohol consumption increases among African-American women, the severity of symptoms associated with comorbid mental disorders, sexual risk behaviors, and consumption of crack/cocaine increases significantly (Zule et al. 2002). Among African Americans identified as individuals who use crack-cocaine, more than 70 percent reported concerns regarding food, clothing, and transportation, and approximately 50 percent reported problems associated with shelter, medical issues, and employment (Zule et al. 2003). With less adequate housing, financial resources, medical care, and higher cumulative stress, African-American women face an increased susceptibility to substance use disorders and other health conditions.

Clinical treatment issues

Beginning in the 1990s, research on African-American women with substance use disorders focused on low-income, urban women who were dependent on cocaine (Roberts et al. 2000). Now, literature on substance abuse and treatment among African-American women

has expanded and environmental stressors have been examined, including psychosocial, sociodemographic, and economic disparities. While research remains limited in the area of treatment approaches and strategies, literature is beginning to reflect promising practices for African-American women.

From the outset, it is vital that African-American women have access to services that provide social support during their pursuit of recovery. Research suggests that African-American women are at risk for substance abuse due to the level of exposure to biopsychosocial and economic stressors and the subsequent difficulty in coping with these life circumstances (Gray and Littlefield 2002). They often experience greater emotional distress and more relationship problems (Liepman et al. 1993; Henderson 1994). Similar to all groups of women, African Americans have very high rates of trauma and abuse, so treatment needs to utilize trauma-informed services.

Coupled with direct and indirect effects of historical trauma (including a history of slavery, lynchings, and racism) (Barnes-Josiah 2004), African-American women disproportionately experience negative health and social consequences of alcohol and drug use (Boyd et al. 2006). For example, African-American women are more likely to have their children legally removed from their custody, in part, as a result of societal bias and discrimination (Wallace 1990). Additionally African-American women are 10 times more likely than Caucasian women to have positive drug screens. Yet, this difference may be directly related to a disproportionate percentage of testing among African-American women (Neuspiel 1996). Subsequently, this threat of loss of child custody or legal sanctions for drug use during pregnancy may prevent African-American women from obtaining prenatal care or seeking substance abuse treatment. Nonetheless, once treatment is initiated, issues surrounding pregnancy, child care, parenting, and custody need be addressed in a nonthreatening but constructive manner—showing support and guidance in promoting and nourishing a healthy parent–child relationship.

Other health consequences include a higher risk for developing alcohol-related disorders, including liver cirrhosis, and a greater propensity to experience toxic effects of cocaine that may lead to earlier onset or greater risk for health problems, particularly cardiovascular disease (D'Avanzo et al. 2001). According to the HIV/AIDS Surveillance Report (CDC 2007), African-American women are 23 times as likely to be diagnosed with HIV/AIDS in comparison to white women, and 4 times more likely than Hispanic women. Among African-American women with HIV/AIDS, 74 percent acquired HIV/AIDS through high-risk heterosexual transmission and 24 percent were infected with HIV through injection drug use. To effectively address pertinent health and clinical issues, treatment programs also need to incorporate HIV/AIDS prevention, intervention, and treatment services.

Coupled with these risk factors, there is a common myth that African-American women “can withstand any amount of pain and keep on working” (McGee et al. 1985; p. 7). This myth may have significant consequences for African-American women who have substance use disorders—delaying treatment, sacrificing self to care for others, and negating the need for preventive health care and substance abuse treatment. (For further review of roles and expectations of African-American women, see Reid 2000.)

Once in treatment, African-American women need a gender-responsive, strengths-based model to develop or enhance a sense of empowerment by recognizing their assets and history of fortitude (Roberts et al. 2000; p. 905). This model provides a framework whereby treatment shifts the focus away from individual internal deficits. For African-American women with substance use disorders, treatment approaches need to extend beyond the general parameters of gender-responsive treatment to include interventions that focus on social contexts across multisystems including social networks or groups, family involvement and therapy, and community involvement and interventions (Boyd-Franklin 1989; Bell 2002). Likewise, spiritual components and Afrocentric

perspectives need to be incorporated into treatment to ensure a holistic approach and to assist African-American women in recovery (Brome et al. 2000; Rhodes and Johnson 1997; Roberts et al. 2000).

Role of spirituality and faith-based recovery

Although there is no “one size fits all” definition of spirituality, spiritual activities nevertheless offer women in recovery an outlet to express problems, seek guidance from others or from a higher power, and move from disharmony to harmony with self and others without fear of repercussion, shame, or punitive actions (Brome et al. 2000). America has an extensive history of religious movements and spiritually led programs that address substance abuse (White and Whithers 2005). Today, there is more focus on the importance of integrating these faith-based approaches into addiction treatment, and more recognition that African-American churches can be a vital recovery tool.

Spirituality has been an important source of support for many African-American women (Lewis 2004). Historically, spirituality and religion have provided a central organizing framework for self-definition, problemsolving, and connection to self and others, especially among African-American women. Black churches have led the promotion of health care, disease prevention, and psychological well-being (Leong 2006). Overall, women in recovery from substance use disorders who express high levels of spirituality demonstrate a more positive self-concept, better attitude toward parenting and perception of family climate, more active coping style, and greater satisfaction with their social support than women who are in recovery but expressed lower levels of spirituality (Brome et al. 2000). Notably, treatment providers need to understand how African-American women relate to traditional religion and spirituality and how that relates to positive mental health outcomes. For an overview of spirituality and religion and its implications for psychotherapy with African-American families, refer to Boyd-Franklin and Lockwood 2009.

Role of an Afrocentric perspective

Though it is important not to make the assumption that all African-American women want to identify with a particular African tradition, acknowledgment of the richness of the African-American heritage or adoption of an Afrocentric perspective is another crucial component of a culturally and gender-responsive treatment program for many African-American women. As an example, The Iwo San Program, located in Cleveland, Ohio, incorporated an Afrocentric component in treatment, along with cognitive-behavioral therapy and an Afrocentric approach to the 12-Step program, with a primary goal of increasing the women's understanding of what it means to be African American and of promoting self-pride through embracing African ancestry, history, and culture (CSAT 2003b). Women learned and used the "Seven Principles" from the Swahili tradition and community as a guide for daily living. (For review, see text box below.)

The concepts of empowerment, the positive role of African-American women in the family and larger community, and the ability to build on their inherent strengths in the face of adversity are important to culturally responsive treatment (Rhodes and Johnson 1997). By incorporating an Afrocentric worldview in substance abuse treatment, African-American women will likely benefit from this critical protective factor

in enhancing self-image, self-esteem, and centeredness in recovery (Roberts et al. 2000).

Role of group, cognitive-behavioral, and family therapy

Group therapy and adapted cognitive-behavioral therapy (CBT) show promise when grounded in the African-American worldview (Brown et al. 1995; Holcomb-McCoy 2004; Washington and Moxley 2003). By placing emphasis on the importance of community, group therapy can be a powerful and culturally appropriate approach that provides a supportive recovery environment and acts as a buffer to stressors associated with recovery. In essence, it is an opportunity to reinforce or rebuild a community connection that supports health. (Refer to Figure 6-1 for a review of promising practices and strategies.)

CBT may be a noteworthy substance abuse treatment approach if adapted to fit the African-American worldview. Yet, minimal research has been carried out on the effectiveness of CBT and substance use disorders. Between 1950 and 2006, only 12 studies have examined CBT among ethnically diverse populations, with only one study focused on substance abuse and CBT (Horrell 2008). While this one study suggests effectiveness with CBT (as measured by reduction in frequency and amount of drug

Nguzo Saba: The Seven Principles

Umoja (Unity)

Kujichagulia (Self-Determination)

Ujima (Collective Work and Responsibility)

Ujamaa (Cooperative Economics)

Nia (Purpose)

Kuumba (Creativity)

Imani (Faith)

Source: Karenga 1998. *Note:* These seven principles are associated with each day of celebration of Kwanzaa.

Figure 6-1

Group Therapy: Promising Practices and Strategies for African-American Women

- Endorse group work to promote values of strong kinship and emphasis on community.
- Promote cohesiveness through closed group formats (same group members from start to finish).
- If feasible, limit group participation to African-American women to enhance safety and comfort.
- Use meditative, spiritual, and experiential exercises to build upon internal strengths.
- Use opening and closing rituals, including a termination ritual at the end of the group.
- Incorporate African ancestry and cultural practices.
- Adapt language to involve recovery in context of family and community.
- Adopt culturally specific content in treatment modules including themes surrounding relationships, spirituality, family, ethnic, and cultural identity.
- Draw upon African-American history as a foundation of recovery, using examples from the work of artists, writers, musicians, heroes, spiritual and political leaders, etc.

Sources: CSAT 2003b; Holcomb-McCoy 2004; Kohn et al. 2002.

use among African-American clients), the results need to be cautiously interpreted due to a high participant dropout rate. To date, more research is needed to examine the effectiveness of CBT with ethnically diverse adult populations with substance use disorders. While research is limited, there is emerging evidence that CBT can be a helpful approach among African-American clients. Kelly (2006) states that CBT may offer African-American women an opportunity of empowerment, supported by a nonjudgmental and collaborative therapeutic relationship, and centered on skill and support system development. It can be easily adapted to match a strength-based approach rather than a deficit model. To help decrease the Eurocentric bias in CBT, clinicians should avoid projecting or overemphasizing the value of cognition without incorporating the relevance of emotional expression and spirituality. As important, CBT should recognize and emphasize the importance of family and community support as an integral part of recovery.

Regardless of approach, treatment should evolve around the premise that family and community are essential elements to healing and

recovery. Treatment programs and counselors can endorse these values within the program by using mentors from the community for women in early stages of recovery (Stahler et al. 2005). Overall, more attention is needed to involve and incorporate a multisystems framework including a family systems approach in treatment. Family therapy is characteristically a more pertinent mode of therapy for African-American women (Boyd-Franklin 1989).

Resiliency factors

Consistent with earlier work (Hill 1972), Gary and Littlefield (1998, p. 99) identified the following resiliency factors in their study of African-American families:

- A high degree of religious or spiritual orientation (as evidenced by church membership, church attendance, a sense of right and wrong, teaching moral values, and a shared religious core)
- A sense of racial pride (telling their children about Black history, discussing racism in one's family, telling children what it is like to be African American, preference for being identified as an African American)

Advice to Clinicians and Administrators: **Substance Abuse Treatment and African-American Women**

Clinical:

- Incorporate a strengths-based approach versus reliance on a traditional deficit model.
- Use an Afrocentric perspective, when appropriate and welcomed, to provide a framework for recovery.
- Involve family members and community to build a network of safety and support.
- Recognize the relevance of spirituality with the client, and encourage involvement to enhance or secure recovery.

Program Development:

- Use elements of the African-American heritage or adopt an Afrocentric perspective to provide a more culturally responsive treatment program.
- Create program policies and procedures that support rather than limit family and community involvement.
- Develop treatment strategies that strengthen a sense of community within the treatment program, and create avenues to broaden this sense of community beyond the program; i.e., providing outreach activities or inviting community members to treatment graduation exercises.
- Invest in workforce development for African-American staff.

Staff Training:

- Provide culturally competent staff trainings promoting an understanding of—
 - African-American history and heritage.
 - The role of racism and discrimination in stress-related health issues and substance abuse.
 - The potential role and importance of spirituality in recovery.
 - Various African traditions and beliefs, and the knowledge of resources to support an Afrocentric perspective with the client.
 - The value and necessity of outreach services to the African-American community.

- | | |
|---|--|
| <ul style="list-style-type: none">• A strong achievement orientation (high expectations for achievement and attainment, goal directedness, etc.)• Resourcefulness (possessing personal talents and skills, self-reliance, self-sufficiency, independence, and the ability to cope with crises)• Family unity (possessing a sense of cohesiveness, family pride, family togetherness, and commitment; i.e., the family comes first)• Display of love and acceptance (the ability to affirm one another and to respect, appreciate, and trust one another) | <ul style="list-style-type: none">• An adaptability of family roles (having role flexibility, sharing responsibility, and communicating with one another)• A strong kinship bond (e.g., a high degree of commitment to the family, a feeling of mutual obligation, kin interaction, and support)• Community involvement (service to others and membership and active involvement in community organizations) |
|---|--|

Asian- and Pacific-American Women

Demographics

Asian origins can be traced to many countries, including Cambodia, China, India, Japan, Korea, Laos, the Philippines, Vietnam, and others. By some counts, the number of national and ethnic groups is nearly 50, representing more than 60 primary languages (Barnes and Bennett 2002; Grieco 2001; New York State Education Department 1997). The three largest groups of Pacific Islanders are Hawaiians, Guamanians or Chamorros, and Samoans (from the Mariana Islands, of which Guam is the largest). In all, 24 different groups are considered Pacific Islander, and individuals from many of these groups have migrated to the United States. More than half of U.S. residents who are Pacific Islanders live in California and Hawaii (Grieco 2001). Yet, over the past few decades, the Asian-American and Pacific-Island populations have become increasingly dispersed across the United States (U.S. Census Bureau 2001f).

Asian and Pacific Americans are a rapidly growing group, increasing by more than 7 million over the last 20 years (U.S. Census Bureau 2001c). According to the 2002 Census, Asian and Pacific Americans constitute about 4.4 percent of the total U.S. population (12.5 million individuals), of whom slightly more than half (51.6 percent) are women (U.S. Census Bureau 2001d). Asian- and Pacific-American women represent 13 percent of all women of color (U.S. Census Bureau 2001d). They are a relatively young group with 25 percent under age 18. Asian and Pacific Americans are both more likely to occupy one or the other end of the continuum in educational and income levels—either obtaining the highest educational and income levels or experiencing considerable poverty and a lack of education in comparison to non-Hispanic whites (Reeves and Bennett 2003).

Substance abuse among Asian and Pacific Americans

Although Asian and Pacific Americans constitute about 4 percent of the population, they represent less than 1 percent of admissions to substance abuse treatment facilities in 1999. However, this represents an increase in treatment admissions of 37 percent from 1994 to 1999 among this population (SAMHSA 2004).

Alcohol

In comparison to other ethnic groups, this population has the lowest percentage of current drinking history and of past year alcohol dependence or abuse (SAMHSA 2006). According to the results from SAMHSA's 2006 National Survey on Drug Use and Health (NSDUH; SAMHSA 2007), the rate of binge alcohol use was also the lowest among Asian Americans. Of the 3,951 Asian- and Pacific-American women admitted for substance abuse treatment in 1999, 27 percent of admissions were for alcohol abuse, a relatively low proportion (SAMHSA 2004).

Lower percentages of alcohol intake may be, in part, a result of the genetic disposition of the “flushing” response among Asians (Collins and McNair 2002). More than 25 percent of Asians possess a gene that causes a slower metabolism of normal oxidation of acetaldehyde. With elevated levels of acetaldehyde in the blood, individuals may experience a range of physical reactions including perspiration, heart palpitations and tachycardia, nausea, headaches, and facial flushing. Individual reactions can vary in intensity and time of onset, which also contributes to the amount of alcohol consumed (Weatherspoon et al. 2001).

Alcohol patterns are largely influenced by the norms established within Asian communities in the United States, or by the cultural norms established in the country of origin. The low drinking rates among women of all Asian- and Pacific-American groups seem to derive in part from the large numbers of abstainers among the foreign-born population. Those born in the United States are more likely to use alcohol and tobacco. Various studies have shown that

educated, young, middle-aged Asian-American women, with higher levels of acculturation, are more likely to drink than other subpopulations of Asian-American women (Gilbert and Collins 1997; Towle 1988). Among Asian-American groups of recent immigrant status, it is more difficult to determine specific substance abuse and dependence patterns. In addition, recent immigrants are less likely to seek treatment and less able to access treatment services; therefore, they are not as likely to be represented when assessing prevalence.

Regarding cultural norms, solitary drinking practices generally are discouraged and often carry significant consequences. Among recent and other first-generation immigrants, the importance of maintaining face, coupled

with insufficient understanding of substance use–related problems, can result in denial of substance abuse problems, family sanctioning, or collusion in substance abuse–related behaviors if drinking practices exceed cultural practices and expectations (Chang 2000). According to the TEDS (SAMHSA 2006), 26 percent of Asian and Pacific Americans identify alcohol as their primary drug of choice upon treatment admission.

Illicit drug use

The rates of illicit drug use are relatively low among Asian- and Pacific-American women compared with other racial and ethnic groups. Currently, methamphetamine (33 percent) bypasses alcohol as the primary drug

Advice to Clinicians and Administrators: **Substance Abuse Treatment and Asian- and Pacific-American Women**

Note: Minimal treatment research is available pertaining to substance abuse treatment among Asian- and Pacific-American women. Therefore, information was gathered using literature across various modalities in behavioral health to help support the following recommendations.

Clinical:

- Address the importance of ethnic heritage and assess the level of acculturation in the beginning of treatment in order to avoid making assumptions regarding cultural values, family structure, gender roles, and styles of communication.
- Incorporate drug and alcohol education in order to reduce the stigma attached to substance abuse and dependence.
- Approach treatment from the vantage point of promoting overall health rather than focusing solely on substance abuse; include a holistic connection between body, mind, and spirit. There is value in reframing the presenting problem by placing emphasis on the positive aspects for change.
- Provide a nurturing environment that does not encourage cultural and gender-related tendencies toward self-blame (Kitano and Louie 2002).
- Develop trust and build a therapeutic alliance to help decrease internalized feelings of guilt and shame.
- Honor the importance of family as the focal point, and that maintaining family honor, obligations, and responsibilities are central to women.
- Focus on problemsolving, goal-oriented, and symptom-reduction strategies to circumvent the likely shame associated with delving into past alcohol or drug use behavior.
- Explore the history of trauma and the potential for posttraumatic stress symptoms and disorder. Many older immigrant Asian-American women have been exposed to losses, torture, and other types of war-related trauma.

Advice to Clinicians and Administrators: Substance Abuse Treatment and Asian- and Pacific-American Women (continued)

Program Development:

- Use a psychoeducational model as an integral ingredient in treatment.
- Consider the appropriateness of home visits to engage families from the outset prior to individual treatment services.
- Incorporate native language services or community resources, e.g., interpreter services.
- Provide separate treatment groups for women to reduce restrictions imposed by gender role expectations.
- Develop a psychoeducational family treatment program to support the individual in relation to her family and to provide education regarding addiction.
- Implement a lecture series that addresses both Western and traditional concepts of disease and treatment.
- Consider the adaptation of a peer-to-peer support group to establish or support culturally appropriate individual and community supports for recovery.

Staff Training:

- Provide culturally competent staff training to promote an understanding:
- Of the diversity of Asian- and Pacific-American women and of the relevance of cultural, language, and socioeconomic barriers.
 - Of the role of acculturation in alcohol and drug use practices.
 - That reporting substance abuse problems can be a significant source of shame for women and her family, and can be perceived as hurtful toward family.
 - Of the importance of “otherness” and the relevance of community and family in the perception of self-identity as a women.
 - That family is central, along with the maintenance of family obligations.
 - That individuals with socially stigmatized behaviors, such as drug abuse, may experience significant consequences from their family and community.
 - That traditional gender roles are often restrictive and influenced by generational and acculturation levels.
 - That communication is more likely to follow a hierarchy pattern whereby elders are respected.

Sources: Chang 2000; Kitano and Louie 2002; McGoldrick et al. 1996; Torsch and Xuequin 2000.

of abuse upon treatment admission. After methamphetamine, the most frequent cause of admission for illicit drug use among Asian-American women is marijuana (16 percent), followed by opioids (11 percent), and cocaine/crack (11 percent) (HHS 2008a). Yet, variations exist across subpopulations in drug and alcohol patterns.

Clinical treatment issues

Foremost, treatment providers need to understand, acknowledge, and incorporate cultural values within the treatment process. The family is the center of most Asian and Pacific Island cultures and is an important consideration for effective treatment for women. The definition of family is expansive

“Acculturation... refers to the manner in which individuals negotiate two or more cultures where one culture is considered dominant while the other culture is perceived to have less cultural value” (Leong et al. 2007, p. 424).

and includes not only immediate and extended family members determined by blood and marriage, but also other members of the community. Among women, family ties, loyalties, cultural expectations, and beliefs can serve as a protective factor against substance abuse (Joe 1996). Moreover, the concept and value of interrelatedness among family, community, environment, and the spiritual world is essential in many Asian and Pacific Island

cultures, and these tenets should be woven throughout the treatment program and clinical services (for an overview of treating Asian- and Pacific-American clients and their families, refer to Chang 2000).

More than 65 percent of the Asian-American population is foreign-born (U.S. Census Bureau 2004). Thus, stress specific to immigration and acculturation is more likely. This has significant implications for treatment planning and services in a variety of ways, particularly in accessing and addressing acculturation stress and its relationship to substance use and other psychological symptoms, specifically depression (Chen et al. 2003).

A complex set of barriers to care can discourage Asian- and Pacific-American women from availing themselves of substance abuse treatment and other health care. Asian-American women who do not speak English or whose cultural traditions include a sense of shame for ill health often do not seek medical care (Leigh 2006). The problem is compounded by the unsurprising denial of substance abuse in a climate that favors family ties, a reverence for authority, and the dearth of culturally responsive substance abuse treatment services (Kitano and Louie 2002, p. 352). In addition, women typically

assume the role of primary caretaker, holding the essential responsibility of nurturing and supporting the family, even at the expense of individual health concerns.

The development of empirically supported methods is evolving, yet research relevant to specific treatment needs among Asian- and Pacific-American women is sparse. Borrowing from the field of cross-cultural psychotherapy (Chang 2000; Leong and Lee 2006), treatment requires thorough assessment that includes such factors as circumstances of immigration, degree of assimilation, ethnic background, and health beliefs. The Asian American Multidimensional Acculturation Scale shows considerable promise in assessing women’s multidimensional levels of acculturation (Chung et al. 2004). It provides a more comprehensive assessment of acculturation and its effect on psychological functioning. Although outcome research specific to Asian- and Pacific-American women in substance abuse treatment is lacking, preliminary research with Asian Americans in community-based substance abuse treatment found no overall group differences in treatment retention and outcomes (Niv et al. 2007).

Resiliency factors

As mentioned above, Asian and Pacific Americans share an ethic of hard work and family orientation, as well as a cultural concept of interrelatedness among family, community, environment, and spiritual world. In addition, the following observations have been noted in the literature:

- If incorporated thoughtfully into the treatment process, the family can have a significant influence on treatment outcome. At the very least, consideration should be given to the family’s role in substance abuse as well as to members’ participation in treatment and influence on recovery (Chang 2000).
- Some clients might find incorporation of indigenous treatment modalities—such as healing ceremonies, acupuncture, meditation, massage, tai-chi, and herbal medicines—helpful (Kitano and Louie 2002).

American-Indian and Alaska-Native Women

Demographics

In the 2000 census, those who reported Alaska Native or American Indian as their only race/ethnic group totaled nearly 2.5 million, while the number reporting Alaska Native or American Indian in combination with another race/ethnic group numbered 4.1 million (U.S. Census Bureau 2001e), or 1.5 percent of the U.S. population. Alaska Native/American Indian is the smallest of the four major racial/ethnic groups currently recognized in the United States. Their small numbers, however, mask significant diversity.

The largest concentrations of Native people reside in three States: Arizona, California, and Oklahoma (U.S. Census Bureau 2001f). However, American Indians and Alaska Natives may live anywhere in North America on and off reservations or other forms of tribal land, in rural or urban areas, and within villages (Coyhis 2000). Today, American-Indian and Alaska-Native nations (e.g., Navajo, Iroquois) encompass more than 560 federally recognized Tribes, including more than 220 Alaskan villages, in addition to numerous Tribes that are not yet federally recognized. Historically, this diversity, as well as the separation of this group into many small segments scattered throughout the United States, has complicated efforts to identify commonalities through classification (NIH; ORWH 1999). Nevertheless, some experiences shared by many Tribes have been noted (NIH; ORWH 1999):

- Rapid change from a cooperative, self-sufficient, clan-based society to a family-based community dependent on trade
- Prior government criminalization of the use of native language and spiritual practices
- Deaths of members of the older generations to infectious diseases and war
- Loss of the ancestral lands

The rates of unemployment, poverty, and education; poor health status; and alcohol and drug use vary by Tribe and by region. The current poverty level is 27 percent among

Native Americans (U.S. Census Bureau 2006). Unemployment hovers at about 13 percent for females older than age 16 (Indian Health Service [IHS] 2002). The proportion of family households maintained by women with no spouse is approximately 21 percent (U.S. Census Bureau 2000).

Substance use among American Indians and Alaska Natives

Although representing only 1.5 percent of the U.S. population, American Indians/Alaska Natives represented 2.1 percent of all admissions to publicly funded substance abuse treatment facilities. Of these, 36 percent were female (SAMHSA 2004). Based on the NSDUH, including alcohol and illicit drugs, Native American women were more likely than any other ethnic group to have met criteria for past year need for substance abuse treatment (OAS 2006a). For more comprehensive information on substance abuse treatment, see the planned TIP *Substance Abuse Treatment with American Indians and Alaska Natives* (CSAT in development e).

Alcohol

Nearly 14 percent of Native-American women were dependent on or abused alcohol between 2004 and 2005 (SAMHSA 2007). Compared with other substances, alcohol was by far the most frequently reported reason (52 percent) for admission to a treatment facility among women (OAS 2006a). The data also show that this group initiates alcohol use at an earlier age than other racial/ethnic groups (SAMHSA 2004). Among women of all races aged 35 to 44, 4.9 per 100,000 died of alcohol-related disease. However, the alcohol-related death rate among American-Indian and Alaska-Native women in this age range is 67.2 per 100,000 (IHS 2002). According to the CDC (2001), American-Indian women have higher rates of alcohol abuse, chronic liver disease, and cirrhosis than any other racial/ethnic group in the United States.

Illicit drug use

Among Native Americans, the rate of current illicit drug use (12.6 percent) is higher than

any other race or ethnicity in United States according to the NSDUH (SAMHSA 2006). After alcohol abuse, the most common cause for Alaska Native and American Indian admission to treatment is methamphetamine (15 percent; SAMHSA 2006), followed by marijuana (13 percent), and cocaine/crack (7 percent; SAMHSA 2006). According to one study investigating gender differences among Alaska Natives in inpatient treatment (Malcolm et al. 2006), women reported higher rates of cocaine dependence in addition to alcohol dependence while men had higher rates of marijuana and alcohol dependence. Although the trend for inhalant abuse is declining among American Indians, studies have shown that American-Indian females are using inhalants more than American-Indian males (Beauvais et al. 2002). Among urban American-Indian women who abuse drugs, Stevens (2001) found that most lived below the poverty level, were unemployed and homeless, experienced a particularly high number of pregnancies and stillbirths, and had children remanded to the custody of State and tribal child protective services.

Clinical treatment issues

Substance use patterns and treatment issues among many groups of American Indians and Alaska Natives have not been studied adequately; as a result, many issues specific to these groups are not well known. Overall, wide variations in alcohol and drug use patterns—along with access to treatment and other needed health services—exist across American-Indian and Alaska-Native communities (Berkowitz et al. 1998; Vernon 2007). While similar barriers exist for Native-American women in comparison to other women with substance use disorders, Native-American women often encounter more barriers that impede access to treatment; i.e., economic hardships, treatment accessibility, lack of screening and assessment, and gender-responsive programming (Berkowitz et al. 1998; Parks et al. 2003).

Comprehensive attention to health care and health status is crucial for treatment of American-Indian and Alaska-Native women. Stevens (2001) suggests that medical and

substance abuse treatment providers need to work hand-in-hand to meet the needs of Native-American women, and that primary care providers should routinely screen for alcohol and drug abuse and discuss the negative health consequences of substance use in a culturally responsive manner during regular examinations.

Unfortunately, few American-Indian and Alaska-Native women who abuse alcohol and illicit drugs are referred or enrolled in treatment programs of any type. For Native-American women living in rural areas, available treatment programs usually are neither woman-centered nor culturally specific. Moreover, many Native-American women are reluctant to attend treatment programs with non-Native Americans (Hussong et al. 1994). Some prefer participating in reservation-based programs, while others may be reluctant to participate in small community programs or urban health centers due to concerns surrounding confidentiality (Jumper Thurman and Plested 1998). Others may seek treatment elsewhere but express concerns surrounding available support upon reentering the reservation after treatment (Berkowitz et al. 1998). Subsequently, Native-American women are more likely to need help deciding on the location of their treatment program.

Trauma-informed services

American-Indian women are disproportionately affected by violent crimes, childhood sexual abuse, and physical abuse. Nearly three-fourths (73.3 percent) of Alaska-Native women in one program reported sexual abuse histories (Brems 1996). Beyond specific traumas among Native Americans, treatment programs need to incorporate a culturally responsive framework that understands and addresses the legacy of historical and cumulative trauma (Robin et al. 1997), including forced acculturation and deculturalization (e.g., loss of cultural, community, individual identity) of American-Indian and Alaska-Native communities. These losses have sometimes been expressed in higher suicide and homicide rates among Native-American community members. As part of recovery, women will likely need to address the loss of family members or friends. Likewise,

Advice to Clinicians and Administrators: **Substance Abuse Treatment and Native-American Women**

Clinical:

- Assess for the history of traumatic events, including sexual and physical abuse, and the diagnosis of PTSD.
- Provide trauma-informed services that encompass the impact of cumulative stress from historical trauma to specific trauma.
- Recognize that the role of “helper” may extend beyond substance abuse counseling to seeking advice for other health concerns, for other family members, or for other life circumstances or stressors.
- Acknowledge the importance of family history and extended family members, and as deemed appropriate, involve family members during the course of treatment.
- Explore the woman’s beliefs regarding healing and knowledge of cultural practices. Don’t assume that a Native-American woman follows traditional practices.
- Understand and acknowledge the specific Tribe’s cultural values, beliefs, and practices, including customs, habits, sex roles, rituals, and communication styles.

Program Development:

- Take time to invest in the individual Native community and learn the perceptions toward non-Native counselors.
- Use treatment as a prevention opportunity for FASD. Provide an interactive program that not only educates women on the cause and prevalence of FAS and Fetal Alcohol Effects (FAE), but provides an understanding of the behavioral effects that are often associated with this syndrome.
- Incorporate comprehensive HIV/AIDS prevention and intervention services into treatment.
- Adopt trauma-informed services and consider an integrated model of specific services for substance-use disorders and trauma.
- Combine contemporary approaches with traditional/spiritual practices; i.e., medicine wheel, “Red Road to Wellbriety” (White Bison), smudging, sweat lodge ceremony, and talking circle.
- Implement a skills training program to help Native-American clients learn how to successfully negotiate both traditional and majority cultures after treatment (Hawkins and Walker 2005).

Staff Training:

- Promote an understanding of the role of historical and intergenerational trauma as well as cultural oppression along with its impact on Native-American clients and its role in substance abuse.
- Provide learning opportunities that highlight the nature, history, and diversity of American-Indian and Alaska-Native communities.
- Address biases and myths associated with Native-American clients; e.g., firewater myth.
- Invest in learning the various and specific cultural patterns in coping with stress that may be unique to the specific community or Tribe.

Advice to Clinicians and Administrators: Substance Abuse Treatment and Native-American Women (continued)

Staff Training (continued):

- Review and discuss the prevalence of HIV/AIDS, FASD, suicide and violence, and other health related risks among Native-American communities.
- Use local tribal members as resource people in training and as staff members in treatment programs.

Source: Coyhis 2000; Evans-Campbell 2008; and Trimble and Jumper Thurman 2002.

screening for traumatic events, posttraumatic stress disorder (PTSD), grief, and depressive symptoms should be routine. Treatment programs for Native-American women need to incorporate culturally congruent trauma-informed and integrated trauma services to build a stronger bridge to recovery (Saylor and Daliparthi 2006).

HIV/AIDS prevention and intervention comprehensive services

In 2005, Native Americans ranked third in HIV/AIDS rates, with Native-American women accounting for 29 percent of the diagnoses. While rates vary from community to community (Vernon and Jumper Thurman 2005), the rise in HIV/AIDS cases among Native-American

communities reflects the need for attention in program development and treatment services for substance use disorders among women. Simoni and colleagues (2004) coined the term “Triangle of Risk” in reference to the HIV risk factors: history of sexual trauma, injection drug use, and HIV sexual risk behaviors. Each risk factor is highly interrelated to the other factors and strongly associated

with substance use disorders. While risk factors are not limited only to the “triangle of risk” (Vernon 2007), the prevalence of these risk factors clearly represents the necessity of comprehensive HIV/AIDS prevention and intervention services among Native-American women seeking treatment for substance abuse.

Fetal alcohol prevention services

Fetal Alcohol Spectrum disorders (FASD) are very serious problems in some Native communities. A four-State study showed that fetal alcohol syndrome (FAS) among American Indians and Alaska Natives occurred at the rate of 3.2 per 1,000 population over a 2-year period, compared with 0.4 per 1,000 in the total population of the same four States (Hymnbaugh et al. 2002). As a means of prevention, gender-responsive treatment services have an opportunity to educate Native-American women on the impact of alcohol and drugs on fetal development. By adding prevention approaches for FASD in treatment, women can make better and more informed decisions regarding alcohol use during pregnancy.

Culturally congruent substance abuse services

Treatment professionals must approach health and well-being through the complementary lenses of culture, history, and the beliefs of Native-American people (LaFromboise et al. 1998; Stevens 2001). For many Native-American women, the journey to reclaim their identities and culture is central to recovery (Brems 1996). The most critical feature for

“The work we do today will provide for the freedom of our future generations (Mohawk).”

Source: The Freedom Way: The Native American Program at the Margaret A. Stutzman Addiction Treatment Center, NY

treatment of American-Indian and Alaska-Native women is that programs be culturally responsive, gender-responsive, and community-based, and that they “reaffirm cultural values and consider the individual in the context of the community” (LaFromboise et al. 1998, p. 150). A series of IHS-funded focus groups for women in treatment found that an emphasis on cultural activities was important to the women (Berkowitz et al. 1998), including sweat lodges, powwows, talking circles, tribal music and crafts, traditional foods, and meetings with medicine people and tribal elders. For many women, participating in tribal activities gave them a sense of belonging—some for the first time (Berkowitz et al. 1998). This is important because the reasons that some Native-American women have given for alcohol and drug use include low self-esteem and “not fitting in with the white world” (Hussong et al. 1994). While it should not be assumed that every Native-American woman is traditional; traditional healing should be made available as a treatment option or as an adjunct to treatment.

Family and community involvement

Strong ties to family and community make community-based approaches appropriate because substance abuse is considered a family and community problem (Berkowitz et al. 1998). In some Native-American communities, alcohol consumption is the norm; abstainers may be ostracized. When drinking together is a major family activity, the woman who abstains may, in effect, lose her family. With such high rates of alcohol and drug use, a woman’s family and friends are unlikely to offer strong support for recovery. By acknowledging the role and the importance of family and community in either perpetuating the substance use or in providing a nurturing recovery environment, treatment providers must involve family and community members from the outset. As highlighted in the IHS-funded research on substance abuse treatment for Native Americans, comprehensive treatment must embrace and encourage community involvement and commitment to support long-term recovery (Berkowitz et al. 1998). Literature suggests that the key factor in

maintaining abstinence among Native-American women is the presence of tangible support (Oetzel et al. 2007).

Resiliency factors

In recent years, American-Indian communities have organized to promote their economies and cultures. In the mid-1990s, an Executive Order mandated the establishment of tribal colleges on or near reservations, and at least 50 percent of the registered student population of these colleges must, by definition, be American Indians or Alaska Natives. Currently, American Indians are developing economic enterprises in the casino, recreation, and computer industries. Along with these advances, American-Indian and Alaska-Native peoples are revitalizing their native languages and cultures. Recent trends include movement back to the reservation. In addition, many American-Indian communities are very proactive about substance abuse issues.

On reservations, many women have gone back to talking circles and are promoting the need to do things within cultural, family, and community contexts, including the creation of communities that are alcohol free (Berkowitz et al. 1998). The Williams Lake Band in Canada, for example, has become entirely alcohol and drug free. Another success story involves the Alkali Lake Band in British Columbia, which achieved a communitywide sobriety rate of 95 percent over a 15-year period (Berkowitz et al. 1998).

Sexual Orientation and Women

Demographics

Several factors prevent an accurate measure of the number of women who identify as lesbian or bisexual, among them the absence of standardized terms and definitions of sexual orientation and gender identity (Dean et al. 2000). However, general estimates of sexual orientation as lesbian or bisexual range from 1 to 10 percent of the female population (Laumann et al. 1994; Michaels 1996).

Hughes and Eliason (2002) present definitions that are inclusive and highlight the differences between sexual orientation and gender identity. Their definition of “lesbian” or “gay” is “a woman or man whose primary sexual and emotional attachments are to persons of the same sex” (p. 266). “Bisexual” refers to “men or women who have sexual and/or emotional attachments to both men and women” (p. 266), although typically not at the same time.

Substance Use Among Lesbian and Bisexual Women

Limited research on alcohol and drug abuse has focused on issues related to sexual orientation (Hughes and Eliason 2002). What is known, however, is that within-group differences are significant. Early research attempts, specifically methods of data collection, may have reinforced misconceptions and stereotypical interpretations of substance use within these groups. Studies in the 1970s and 1980s revealed high rates of alcohol use and abuse among lesbians, yet most surveys were conducted at bars. Other methodological limitations that remain consistent to the present time are sample size and absence of control groups (Hughes and Eliason 2002). In addition, studies that evaluate drug patterns are often focused on gay men. Little is known about illicit and prescription drug abuse patterns among lesbian and bisexual women. In two population-based studies, researchers found more drug use and heavy drinking among bisexual and lesbian women than among heterosexual women (Diamant et al. 2000).

Alcohol

Later research (Cochran et al. 2000; Hughes et al. 2000) supports the idea that earlier estimates of the relationship between sexual orientation and alcoholism are inflated. Nonetheless, these and other studies (Case et al. 2004; Cochran et al. 2000, 2001; Cochran and Mays 2000; Gilman et al. 2001; Parks and Hughes 2005; Sandfort et al. 2001) suggest that lesbian women—in comparison to heterosexual women—are more likely to use and abuse alcohol, less likely to decrease their use of alcohol with age, and

more likely to report alcohol-related problems. Literature suggests that this greater prevalence of substance use and abuse may be related to more opportunities to drink, fewer traditional sex role expectations, and different social conventions about drinking (Hughes and Wilsnack 1997).

Illicit drugs

While little is known about drug patterns among lesbian and bisexual women, research suggests that they are at a heightened risk for drug use, with specific subpopulations showing more prevalence, such as young adult lesbian women (Hughes and Eliason 2002). In two studies (Cochran et al. 2004; Corliss et al. 2006), researchers report that women with female sexual partners had at least one symptom of dysfunctional drug use and were more likely to display impairment and meet criteria for any drug dependence in comparison to heterosexual women. Lesbians report greater problems associated with marijuana, cocaine, and hallucinogens. In a study conducted in urban primary care sites, bisexual women were about twice as likely as heterosexual women to report having used illicit drugs in the past month (Koh 2000).

Clinical Treatment Issues

Few studies of substance use disorders have included sufficient numbers of lesbian women to permit separate analyses, and no studies have focused exclusively on bisexual women. In the few studies that are available, findings are inconclusive regarding the efficacy of separate treatment groups. Only 6 percent of substance abuse treatment services offer special programs or group therapy for gay men and women (SAMHSA 2005). For a comprehensive overview of treatment issues among lesbian and bisexual women, review SAMHSA’s Center for Substance Abuse Treatment (CSAT) manual, *A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals* (CSAT 2001b). This manual provides information to administrators and clinicians about appropriate diagnosis and treatment approaches that will help ensure

Advice to Clinicians and Administrators: **Substance Abuse Treatment and Lesbian and Bisexual Women**

Clinical:

- Explore coping style and enhance coping skills needed to manage stress associated with self-disclosure and the habitual “coming out” process, to deal with attitudes from others regarding sexual orientation, and to address feelings of alienation from family members who are rejecting of sexual orientation.
- In addition to appropriate family members, consider friends as a vital component of treatment and support structure. Studies (Kurdek and Schmitt 1986; Mays et al. 1994) report that lesbians generally receive greater support from friends than from family. By using social support from family and friends, counselors will likely enhance psychological well-being.
- Assess for interpersonal violence. Rates pertaining to partner violence or abuse among lesbian women are similar to those of heterosexual women (see, e.g., Coleman 1994; Renzetti 1994) and partner abuse often is accompanied by alcohol use (Schilit et al. 1990). Assess for the history of traumatic events, including sexual and physical abuse, and the diagnosis of PTSD.

Program Development:

- Consider a specialized group that addresses issues unique to lesbians in recovery.
- Implement policies that address the potential woman-to-woman sexual relationships that can develop in residential treatment (similar to man-to-woman relationship policies in treatment).
- Incorporate educational components in treatment that address relevant legal issues and the inherent issues that may arise in addressing medical, child custody, and financial needs.

Staff Training:

- Provide education on the multiple risk and protective factors that may either increase or buffer risk for substance use disorders.
- Impart knowledge about legal issues, including living wills, powers of attorney, advance directives, restrictions imposed by HIPAA, as well as a referral base to assist lesbians in securing these services.
- Address myths and stereotypes associated with gender roles and sexual behaviors, including the possible assumption that lesbians in relationships play either male or female roles or they are hypersexual or promiscuous. It is important for staff to recognize that lesbian relationships maintain the same patterns of stability and sexual behavior as heterosexual relationships.
- Review supportive strategies in assisting clients in determining whether or not to self-disclose sexual orientation in treatment.
- Assist staff to understand the impact of stigma associated with lesbian and bisexual women.
- Review the “coming out” process and the stages of identity.

Source: Ayala and Coleman 2000; CSAT 2001b; Jordan and Deluty 1998; Oetjen and Rothblum 2000; Wayment and Peplau 1995.

the development or enhancement of effective lesbian, gay, bisexual, and transgender (LGBT)-sensitive programs.

Sexual Orientation and Women of Color

Prevalence studies of substance use and abuse in lesbian, gay, and bisexual populations rarely have included sufficient numbers of racial and ethnic minority persons to permit separate analyses. However, limited available data suggest that patterns of substance use among lesbian women of color are more similar to those of their Caucasian lesbian counterparts than to those of their heterosexual racial and ethnic counterparts (Hughes and Eliason 2002). All racially and ethnically diverse group members face similar responses to their sexual orientation that can be stressful to psychological well-being, and reluctance to seek professional help can increase further their risk for negative psychological outcomes (Greene 1997).

Social support for treatment is known to be important in helping women stay in treatment and avoid relapse. Although African-American lesbian and bisexual women may receive support from fewer sources than African-American heterosexual women when they are in treatment for alcohol dependence, the quality of that support appears the same for the two groups (Mays et al. 1994). African-American gay women may prefer counselors of the same race who identified themselves as lesbians (Matthews and Hughes 2001).

Relatively little is known about alcohol abuse among Hispanic/Latina lesbian and bisexual women, although some researchers (Nicoloff and Stiglitz 1987; Peluso and Peluso 1988) believe it is more prevalent among Hispanic/Latina lesbian women than heterosexual Hispanic/Latina women (Reyes 1998).

For Asian Americans, cultural issues play a major role in sexual identity and culturally normative behavior. Asian-American lesbian women pose a cultural dilemma by virtue of their individual and sexual identification. If sexuality is expressed without jeopardizing family integrity and the individual's role in the

family, then it may be tolerated (Chan 1997). Many Asians find it difficult to conceive of losing that familial connection and are therefore uncomfortable with assuming a minority sexual identity. Given this context, it is likely that Asian Americans who are openly lesbian probably are relatively acculturated. Chan (1989) found that, although they identify both with their Asian-American and lesbian identities, most of these women identify more strongly as lesbian. The implications of this with regard to substance abuse remain unexplored.

American Indians and Alaska Natives traditionally uphold a worldview that all things are interrelated and dependent upon one another. Identity formation, specifically sexual identity, is conceptualized through this broader lens. Therefore, sexual identity is typically not defined using definitive terms, such as lesbian or bisexual, but rather through more expansive concepts that embrace roles within the culture and community. Native Americans are more likely to use the term “two-spirit” to capture both male and female sexuality and gender expression (Evans-Campbell et al. 2005). Research focused on substance use disorders among two-spirited Native Americans is limited, and empirical literature highlighting two-spirit women is non-existent. In a study comparing two-spirited men and women with Native heterosexual peers, two-spirit individuals had significantly higher rates of lifetime illicit drug use; greater sustained drinking among urban Natives; and greater likelihood to use alcohol to increase sociability, regulate mood, and decrease anxiety and feelings of inferiority (Balsam et al. 2004).

Resiliency Factors

In general, lesbian women are more likely to have long-term relationships and friendships similar to heterosexual women. The stability in relationships may provide a strong platform in recovery provided the environment does not support or encourage continued alcohol abuse or drug use. Moreover, the woman's fortitude

in managing prejudice and discrimination as a direct result of sexual orientation may provide a powerful example and symbol of personal strength in working toward recovery.

Women in Later Life

Demographics

Approximately 21 million women aged 65 and older reside in the United States. In 2003, women accounted for 58 percent of the population aged 65 and older (Federal Interagency Forum on Aging-Related Statistics [FIFARS] 2004); women older than age 65 constitute 7.3 percent of the total population. The oldest of the population (persons 85 years and older) are among the most rapidly growing age cohort in the Nation. The increasing number of older women corresponds to a growing incidence of health-related problems that were once considered solely men's diseases.

A Hidden Disease

Older years are filled with many adjustments and challenges, often including loss of spouse and close friends, retirement, and reduced income. Some women turn to alcohol or drugs to help meet these life changes. Because many older women live alone (40 percent of those aged 65 and older [FIFARS 2004]), their substance use is difficult to measure (Moore et al. 1989). Older women tend to hide their substance use because they attach greater stigma to it than men do (CSAT 1998d). Older women are less likely than older men to drink or use drugs in public, so they are less likely to drive while intoxicated or engage in other behavior that might reveal a substance use disorder (SAMHSA 2008).

Substance use disorders in older women often go undetected by primary care professionals because of a lack of appropriate diagnostic criteria and because many signs of abuse can be mistaken for other conditions more prevalent in later life (e.g., cognitive impairment, anemia, physiological consequences from falls). It is not unusual for older patients to show poor compliance with the recommended use of their medications (Menninger 2002). TIP 26

Substance Abuse Among Older Adults (CSAT 1998d), recommends best practices to identify, screen, assess, and treat alcohol, prescription medication, and other drug abuse among people aged 60 and older.

Risk Factors

Alcohol dependence and prescription drug abuse are the top two substance use issues for older women (CSAT 1998d). Numerous risk factors are associated with substance-related problems among older women including losses or deaths, financial problems, health problems, age-related changes in metabolism, synergistic effects in combining alcohol and other drugs, and changing roles (Epstein et al. 2007). Researchers found that when women were deprived of their usual roles as wife, mother, or employee, their problem drinking increased. Older women with fewer role demands have fewer competing activities (Wilsnack and Cheloha 1987).

Timing of Onset

Alcohol- and drug-related problems in older women can be longstanding or can begin in later life. Women with early-onset alcohol dependence have a high incidence of major depression, anxiety, and bipolar disorder and simply continue their drinking habits as they age (CSAT 1998d). Women with late-onset use appear both physically and psychologically healthier. They are more likely than those with early-onset use to have begun or increased drinking in response to a recent loss such as death or divorce. Both groups appear to use alcohol almost daily outside the home and at home alone and are likely to use alcohol to respond to hurts and losses (CSAT 1998d).

Substance use among women in later life

Alcohol

In comparing trends from 1992 to 2002 in alcohol abuse and dependence among women as they age, the National Epidemiologic Survey on Alcohol and Related Conditions showed a significant inverse relationship between rates of dependence and successive age groups—that as

Signs of Alcohol-Dependence and/or Drug Abuse in an Older Woman

- Neglected appearance and poor hygiene
- Frequent car accidents
- Numerous physicians and prescriptions
- Neglect of home, bills, pets, etc.
- Malnutrition and anemia, and empty food cupboards
- Withdrawal from social activities and self-isolation from family and friends
- Mood swings or erratic behavior
- Repeated falls or evidence of falls (leg bruises)
- Urinary incontinence
- Cigarette burns
- Attempts or thoughts of suicide
- Depression
- Unexplained chronic pain or other health complaints
- Confusion and/or memory impairment
- Blurred vision or blackouts
- Seizures or tremors

Source: Cohen 2000; CSAT 1998d

women age, prevalence of alcohol dependence decreases (Grant et al. 2006). While there is earlier empirical evidence to support that late-middle-age to older women have fewer drinking problems (known as “maturing-out”; Brennan et al. 1993), this trend has to be approached with a conservative lens since older women tend to hide their use and not seek alcohol treatment. In addition, the prevalence and risk of alcohol abuse and dependence among women appears to vary among subgroups. For example, widowed women were found to be three times more likely than married women to drink heavily (The National Center on Addiction and Substance Abuse at Columbia University [CASA] 1996). The most consistent predictors of alcohol-related problems among women were friends’ approval of alcohol use, financial stressors, and avoidance coping (Moos et al. 2004).

Prescription Drugs

Prescribed medications are the most common drugs of abuse, outside of alcohol, among

older adults (National Institute on Drug Abuse [NIDA] 2001). Approximately 30 percent of all prescriptions and 40 percent of all benzodiazepine prescriptions are prescribed to elderly individuals. An older woman is more likely than an older man to visit a physician and to be prescribed a psychoactive drug. Problems can result if prescriptions are written by several physicians who do not know the full range of prescribed and over-the-counter medications being taken. Older women often are prescribed medications highly susceptible to abuse (NIDA 2001). Medications frequently prescribed for and used by older women include anxiolytics and sedative-hypnotics. Alcohol–drug interactions are more likely to occur among older adults simply because they take more medications than younger adults and may continue to drink at levels consistent with earlier patterns. These interactions can cause problems in older adults because of slowed metabolism in later life and greater reliance on medications for chronic medical conditions (CSAT 1998d). With

Advice to Clinicians and Administrators: **Substance Abuse Treatment and Older Women**

Review TIP 26 Substance Abuse Among Older Adults (CSAT 1998d), for further guidance in providing substance abuse treatment to older women.

Clinical:

- Introduce coping strategies, including relaxation methods, to enhance feelings of self-efficacy in handling life stressors.
- Incorporate counseling services that address issues of grief along with substance abuse treatment as needed.
- Use additional resources to reinforce the need for and support of treatment including, but not limited to, extended family members, healthcare providers, faith-based services, etc.
- Incorporate behavioral activation therapy to help address depressive symptoms among older women who have substance use disorders. This behavioral approach helps clients to recognize the connection between life stressors, mood, and less effective coping behaviors. It encourages and provides strategies to help the client to monitor mood and daily activities with an emphasis on strategies to increase the number of enjoyable activities (Cuijpers et al. 2007).
- Recognize and address the potential losses associated with changes in caregiver roles.

Program Development:

- Create access to treatment through nontraditional delivery; e.g., home-based or mobile community services.
- Provide educational programs on metabolism and interaction of alcohol and drugs, particularly prescription medications, at senior citizen centers.
- Create addiction treatment services or programs designed for older adults only.
- Provide home services or develop a one-stop multidisciplinary program that provides needed healthcare and nutritional services, psychoeducational groups, financial services, transportation, counseling, etc.

Staff Training:

- Review the more common signs of drug misuse among older women, including mental and physical symptoms as well as suspicious requests for refills.
- Provide an introduction to prescription drugs with emphasis on the physiological effects of anxiolytics and sedative hypnotics.
- Provide education on the physiological impact of alcohol and drug intake among older women.
- Emphasize the heightened alcohol sensitivity among women and the increased vulnerability among older women.
- Explore the relationship between alcohol problems and higher rates of depression and prescription drug use.
- Address the need and roles of a multidisciplinary treatment to ensure quality of care for older women in substance abuse treatment.

Source: Eliason and Skinstad 2001; Satre et al. 2004; Scogin et al. 2007.

age-related changes, prescription medications are more potent, less predictable in effects, and more likely to increase negative outcomes (Allen et al. 2006).

Clinical Treatment Issues

Screening and brief interventions, particularly cognitive-behavioral and case management approaches, may be especially useful in limiting alcohol abuse in older women; although research with older women has been limited, results are promising (Blow and Barry 2002). Alcohol dependence in an older woman may be observed first when she presents at an acute-care medical setting with complaints such as depression, memory loss, frequent falls, or chronic pain that may have been exacerbated by alcohol. These are not and should not be presumed to be normal consequences of aging. This is an appropriate time to intervene and discuss the benefits of sobriety as well as treatment options.

Treatment should be supportive, respectful, and non-confrontational. If possible, providers should gather personal information about the client from family members, neighbors, clergy, or others with the client's permission. Labels such as "alcoholic" or "addict" should be avoided and replaced with words such as "drinking" and "drinking problem" (Cohen 2000). It is important to be direct and honest, to explain that assistance is available, and to provide instructions on where help can be secured. A substance abuse treatment professional can help the older woman develop a support system. Some women may respond better if approached about their drinking in the safety of their homes or at a familiar medical facility where they feel comfortable. Programs such as Alcoholics Anonymous can be an important resource, particularly if the group meets during the day and is composed of older women.

A well-coordinated approach to substance abuse treatment for older women should include an interdisciplinary treatment team with family or significant others involved in a plan of individualized support services. Since it may be difficult to address the needs of older women in residential treatment programs (where the

majority of clients are much younger), treatment may be more effective when delivered at senior centers, congregate meal sites, outpatient geriatric medical programs, nursing homes, home care programs, or peer outreach (Cohen 2000). Recent studies are providing promising results. In an outcome study comparing men's and women's abstinence rates in an outpatient group, 79 percent of women reported abstinence from alcohol at the 6-month followup, compared to 54 percent of the men (Satre et al. 2004).

Resiliency Factors

Using a strengths-based narrative approach can help capitalize on each woman's life experiences and give meaning to her recovery. By providing an opportunity to explore her life events, history, personal attributes, and triumphs in spite of adversity, counselors can use this history to help reinforce the woman's resilience and abilities to support recovery.

Women in Rural America

Demographics

Rural America contains 17 percent of the U.S. population (Economic Research Services 2007). In many rural areas, the population is aging steadily. Rural areas have a higher proportion of older persons and higher poverty rates among the elderly than urban areas, and women constitute 65 percent of the rural poor age 65 and older. In addition, poverty rates in rural settings are three times higher for widows than for married women (USDA 2007).

In reviewing specific hardships that may not be independent of the effects of either chronic or acute alcohol and drug use, a welfare study identified common material hardships experienced by women. More than 56 percent of rural women respondents report unmet medical needs and telephone disconnection as the most prevalent hardships, followed by food insufficiency, housing problems, improper winter clothing, and utility disconnection (USDA 2007). With added burdens generated by age, substance abuse, and poverty, local communities

are faced with many challenges in meeting the diverse needs of women in rural settings.

Substance Use Among Women in Rural Settings

Substance abuse is a major rural health concern. While alcohol and drug patterns vary little across most age groups in urban and rural settings, emerging patterns among rural youth show a rise in use—thus providing a forecast of potential patterns of abuse and dependence. While rural and urban areas experience similar drug-use problems, the consequences may be greater in rural areas because of limited access to health care and substance abuse treatment. For example, only 10.7 percent of hospitals in rural areas offer substance abuse treatment services compared to 26.5 percent of metropolitan hospitals (Dempsey et al. 1999). Currently, there are minimal studies focused on substance use disorders among rural women (Boyd 2003).

Risk factors for substance use disorders among women living in rural areas of the United States are significant. Many rural families are impoverished, and women often experience stress associated with limited resources (Boyd 1998). A history of childhood victimization is another risk factor for substance use disorders among rural women, as for all women. A qualitative study described rural women's perspectives on becoming alcohol dependent, and many reported some form of sexual abuse. This study reported that some rural women began drinking in adolescence as a means of self-medication to ease the pain of their problems (Boyd and Mackey 2000*a, b*).

Alcohol

Beliefs and expectations about alcohol strongly predict potential alcohol abuse. Women in some rural communities hold more positive beliefs about alcohol than those in other communities or in comparison to urban women. The beliefs involve the notion that alcohol enhances sexual, physical, and social pleasure; reduces tension; and increases arousal, power, and control over life circumstances (Boyd 1998; Marlatt et al. 1988).

Clinical Treatment Issues

Poverty is a significant barrier in obtaining health services, and this barrier is more common for women than for men, especially in rural areas. Women in some segments of rural America perceive financial barriers to health care significantly more than men in rural areas and, consequently, experience poorer health than men (Beck et al. 1996*b*). Women with substance use disorders who live in rural areas may face a unique set of clinical issues that may challenge substance abuse professionals. These issues can include greater geographic and personal isolation, limited access to substance abuse treatment and mental health services (Ryland and Lucas 1996), poverty, and issues of confidentiality. While rural women often face the same obstacles in obtaining substance abuse treatment services that challenge women anywhere, rural women are more likely to encounter a lack of child care, available treatment slots, transportation, and phone service, and possess a reluctance to address and disclose to staff (Tatum 1995).

Treatment programs need to be culturally and ethnically appropriate for the community. Clinicians and other staff members may need to consider issues such as distance (e.g., how many miles from home to clinic), time and season

Beyond the traditional therapy method used in many urban areas, the Appalachian tradition of storytelling has been used to help rural clients engage in treatment, gain insight into their problems, and learn new coping skills to address problems associated with substance use (Leukefeld et al. 2000).

Advice to Clinicians and Administrators: **Substance Abuse Treatment and Women in Rural Areas**

Clinical:

- Screen for co-occurring disorders, and refer as needed.
- Obtain a history of traumatic events, including sexual abuse.
- Incorporate screening procedures to aid in appropriate referral to other health and social services.
- Explore potential reluctance in seeking help outside of immediate community.
- Assess for a history of interpersonal violence, and recognize that rural women have often reported learning that violence toward women is acceptable.
- Explore beliefs and attitudes toward alcohol and drug use.

Program Development:

- Develop partnerships among other local agencies and neighboring communities to share resources to aid in the delivery of services in remote areas.
- Develop a center that houses a network of services including health, mental health, substance abuse, and other social services.
- Develop a screening, assessment, and referral service for substance use disorders within the Temporary Assistance to Needy Families (TANF) program.
- Provide services that support substance abuse treatment attendance including child care, transportation, and mobile treatment.
- House support groups in the treatment facility, and consider providing or subsidizing transportation as a means of continuing care support.
- Create professional training, network activities, and opportunities for staff to decrease feelings of isolation and staff turnover and to invest in workforce development.
- Develop psychoeducational community programs to help reduce alcohol and nicotine use during pregnancy.
- Consider the use of telecounseling services in rural areas for assessment, pre-treatment, counseling, and/or follow-up services.
- Develop outreach services to address substance use and abuse issues among the aging population of rural women.

Staff Training:

- Emphasize the prevalence of social shame among rural women who have substance use disorders.
- Discuss the cultural issues that may support a reluctance to seeking treatment outside of the immediate community.
- Review the challenges of anonymity in small communities, the strategies that can enhance privacy, and the need to address and ensure confidentiality in treatment.
- Examine the potential hidden attitudinal barriers among women seeking substance abuse treatment including distrust of the “system,” expectation of failure, and positive beliefs regarding the benefits of alcohol and/or drug use.

Source: Baca et al. 2007; Boyd 1998; 2003; CSAT 2003b; Howland 1995; Wilkins 2003.

(e.g., the demands of planting and harvesting, coordinating appointments with other trips to town), and even weather conditions to provide culturally acceptable services to rural clients (Bushy 1997). Another aspect of rural life is that communities are smaller and more close-knit so that everyone is familiar with the personal affairs of his or her neighbors. If, for example, a woman is arrested for driving under the influence, the chances are significant that the person in authority knows her or her family (Boyd 1998). Similarly, women in rural areas may know the law enforcement authority and, perhaps, know the substance abuse treatment provider as well. For rural women entering treatment who have been abused, their abusers may also be well known to the community. Prior reports of abuse may or may not be believed, and may set off counter-reactions against her.

Women may wish to seek treatment outside the community, even if they have to travel long distances. They may choose not to be seen going to the counselor's office or may have a preexisting relationship with the counselor. Conversely, women from rural communities may be reluctant to seek treatment outside of their communities, viewing treatment providers as "outsiders." As to other identified clinical issues among rural women with substance use disorders, the incidence of co-occurring disorders is suspiciously lower than among women from major metropolitan areas, perhaps because it is underdiagnosed and, as a result, undertreated (Kessler et al. 1994).

Several treatment programs have been developed for use with rural residents. Among these is Structured Behavioral Outpatient Rural Therapy (SBORT), a cognitive-behavioral intensive outpatient approach consisting of two phases: pretreatment and treatment. The three-session pretreatment phase consists of individual counseling to increase readiness for change. The treatment phase involves 12 sessions in 6 weeks and consists of storytelling and "thought mapping" to develop recovery skills (Clark et al. 2002). Storytelling is used to encourage clients to share their experiences and to help them relate to the presenting material in treatment. During thought mapping, the group examines important

incidents before and after prior use of alcohol or drugs. Treatment focuses on problemsolving strategies and other cognitive strategies, relaxation techniques, coping skills to deal with cravings, and encourages the utilization of self-help (Hall 1999). Specific outcome studies on SBORT for rural women in substance abuse treatment are lacking.

Resiliency Factors

In rural communities, there is typically a pattern of stability in residence, interpersonal relationships, and community. This stability can be a protective factor in recovery by providing sustained support. Likewise, large extended families, involvement in religious activities, and faith are attributes that are not only common in rural America but can serve as a conduit for treatment (Van Gundy 2006). From prevention to continuing care, counselors and administrators need to take advantage of these qualities in programming and clinical practice.

Resources for Other Special Populations and Settings

Women With Physical and Cognitive Disabilities

Review TIP 29 *Substance Use Disorder Treatment for People with Physical and Cognitive Disabilities*. This is a practical resource for information on addressing treatment issues in this population (CSAT 1998e).

The 2000 Census reported that about 44 million noninstitutionalized adults have disabilities, including approximately 20 percent of adults younger than age 65 and 40 percent of those older than 65 (U.S. Census Bureau 2002). These individuals span all ages and racial, ethnic, and cultural backgrounds. One study (Larson et al.

2005) found that women with trauma histories and co-occurring substance use and mental disorders had high rates of physical disabilities, with the greatest number (15 percent) of disabilities being injury/musculoskeletal/connective tissues problems. Although little research exists regarding the extent of combined disability and substance abuse, people with disabilities generally use substances at the same or higher rates than those without disabilities (CSAT 1994e). In some cases, the disability can exacerbate the risk factors for substance use disorders.

Women with disabilities are affected by several factors that can increase the likelihood of substance abuse and dependence (Ferreira 2005):

- Increased dependence on others for basic needs
- Potential use of prescription medication for chronic pain
- Facilitation of substance use by family and friends to help cope with the disability
- Social isolation (lack of social support, unemployment, etc.)
- Insufficient referral for substance abuse treatment by primary physician or caregiver caused by lack of recognition
- Inaccessible substance abuse treatment programs

Women in the Criminal Justice System

Women in criminal justice facilities face numerous challenges including, but not limited to, greater health issues and higher prevalence of co-occurring disorders; increased likelihood

of pregnancy and need for prenatal care; history of sexual violence and other forms of abuse; and childcare, custody, and parenting issues. The number of female inmates in all criminal justice facilities has been increasing at a faster rate than the number of male inmates. Between 1995 and 2002, the average annual growth rate of incarcerated females was 5.4 percent, compared with 3.6 percent for males (Harrison and Karberg 2003). Among the prison population, from 1990 to mid-2001, the number of female inmates jumped 114 percent; the male population grew by 80 percent in the same period (Beck et al. 2002). African Americans and Hispanics/Latinas account for nearly two-thirds of incarcerated women. Their median age is in the 30s. Nearly half of those in State prisons and other correctional facilities have never been married (Greenfield and Snell 1999).

Among State prisoners, females were more likely than males to be sentenced for drug offenses (29 percent versus 19 percent; Sabol et al. 2007). Among Federal defendants in 2004, the leading drug arrests and sentences among women were related to methamphetamine (Bureau of Justice Statistics 2004). Women were more likely than men to have used methamphetamines in the month before their offense (Bureau of Justice Statistics 2006). According to U.S. Department of Justice, an estimated 52 percent of females in comparison to 44 percent of males incarcerated in local jails were dependent on or abusing drugs. In the last decade, more than half of all female prisoners reported being under the influence of alcohol or drugs at the time they committed the crime, with drug use being more prevalent (Greenfield and Snell 1999). In addition to TIP 44 *Substance Abuse Treatment for Adults in the Criminal Justice System* (CSAT 2005c), refer to *Gender-Responsive Strategies: Research, Practice, and Guiding Principles for Women Offenders* (Bloom, Owen, and Covington 2003) for more information.

Review TIP 44 Substance Abuse Treatment for Adults in the Criminal Justice System. This is a practical resource for information on addressing treatment issues in this setting (CSAT 2005c)

Women Who Are Homeless

Review the planned TIP *Substance Abuse Treatment for People Who Are Homeless*. This TIP is a practical resource for information on addressing treatment issues in this setting (CSAT in development g).

According to the Annual Homeless Assessment Report to Congress (2008), nearly 3 percent of Americans experience homelessness at any one time. Approximately 23 percent are chronically homeless with homelessness disproportionately affecting African Americans (44 percent of the total homeless population). Less is known about homeless women. Data collections often have missing personal identifiers, leading to less than reliable estimates of homeless women and homeless women and their children.

In exploring factors associated with women who are homeless (literal definition of homelessness: sleeping in shelters, public places, abandoned buildings, etc.), literature suggests significantly higher prevalence rates of domestic violence and serious health problems including HIV. Most women who are homeless do not have a criminal record. Nearly half never lived independently prior to losing their housing arrangement, and that housing arrangement mainly disintegrated between the woman and extended family

members, spouse, or significant other. More than 25 percent reported loss of employment as the immediate cause of homelessness, while another 25 percent of women reported domestic violence as the cause (Levin et al. 2004). Other factors that contribute to homelessness include illness, recent relocation (Lehmann et al. 2007), hospitalization, severe mental illness, substance use disorders, high-risk pregnancy, increased rents, or fire (SAMHSA 2003b; Levin et al. 2004). The majority of women who are homeless using shelters have children (83 percent; HUD 2008). It is estimated that 84 percent of homeless adults with families are women (AHAR 2007).

Substance abuse among women who are homeless

Alcohol abuse and drug use has increased among homeless women in the past 20 years (North et al. 2004). Numerous studies (Koegel et al. 1999; North et al. 2004a; Robertson et al. 1997) provide estimates on lifetime and current substance use disorders among homeless women with lifetime estimates ranging from 56 to 63 percent and current estimates spanning 38 to 58 percent. Twenty percent of homeless admissions to substance abuse treatment are women, with admission rates higher among African-American women. Upon admission, prevalence rates of alcohol-related admissions were similar to all female admissions, while prevalence of cocaine/crack and heroin were more likely reported among homeless women (OAS 2004a).

SAMHSA offers a Homelessness Resource Center, a virtual community located at www.homeless.samhsa.gov. For providers who serve the homeless, this site offers information on a wide range of programmatic and clinical topics, provides access to related resources, including a one-stop site for all Federal Government materials on homelessness, and provides a place to share ideas and to gain support.

Appendix A: Bibliography

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