

# **Counseling Women Who Abuse Substances**

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## ***Section I – Introduction and Overview***

### **Extent of the problem**

The prevalence of women's alcohol and other drug use in the United States is well documented. In the general population, alcohol abuse or dependence is more frequent among men than women. The same pattern holds true for most other commonly abused substances and, not surprisingly, the number of men admitted for substance abuse treatment far exceeds the number of women admitted.

However, approximately 6 million women abuse alcohol or are dependent on it. Of women who drink, 13% have 7 or more drinks per week, which exceeds dietary guidelines issued by the U.S. Department of Agriculture and the U.S. Department of Health and Human Services. In general, the rate of alcoholism among women is catching up with men's rate of alcoholism, especially among certain groups of women (i.e., young professionals, women born after 1953).

When it comes to smoking, the gap between men and women is narrow. Approximately 20% of U.S. women are smokers. Teenage girls smoke at almost the same rate as boys. And with prescription drugs, women are 48% more likely to be prescribed a narcotic, an anti-anxiety medication, or other potential drug of abuse. More than 42% of women have used an illicit drug at some point in their life and over 6% of women report using an illicit drug in the past month.

Many women's problems with substance abuse continue while they are pregnant. Seventeen percent of pregnant women smoke, 3% binge drink, and 3% use illicit substances.

Overall, substance abuse and dependence is much higher among adult males than it is among adult females. However, findings from a 2008 national survey paint a disturbing picture about the future. The percentage of females age 12-17 who were substance abusers or dependent was higher than males in the

same age range. Although the rate of substance abuse or dependence among women age 18 or older decreases with age, this nevertheless can lead to a host of problems.

### **Other differences between men and women**

Women with substance problems often have fewer resources (i.e., employment, income) than men, are more likely to live with a partner who abuses substances, and are more likely than substance abusing men to be the primary caregiver for dependent children. But compared to men, women...

- Become addicted to alcohol, nicotine, and other drugs at lower levels of use and in shorter periods of time;
- Get higher concentrations of alcohol in their system and become more impaired than men after drinking an equivalent amount of alcohol;
- Tend to develop alcohol-related liver disease and liver, brain and heart damage more quickly. This is partly due to women having lower levels of alcohol dehydrogenase, a chemical that breaks down alcohol in the digestive system before it moves into the bloodstream.

And of course, women who drink, smoke, or use illicit drugs are at higher risk for these and other consequences compared to women who do not use substances.

Despite the shorter distance from the onset of substance abuse to serious long-term effects, an estimated 88% of women who need treatment do not get it.

### **Historical Background**

In colonial America, it was considered acceptable for women to drink at home, but not in taverns. Although they drank more in public by the 19<sup>th</sup> century, women were still judged more harshly than men who drank alcohol. Women who drank excessively could be subject to harsh measures such as imprisonment or sterilization, a practice that continued into the 20<sup>th</sup> century.

After Prohibition was overturned in the 1930s, women began drinking more frequently and more openly. The percentage of women who drank rose as high as 66% in 1981, but later declined to its current rate.

Male clients were the frame of reference for the original body of research and theories related to the addiction treatment field. These disorders appeared more prevalent in the male population, so it was assumed the progression of the disease in women mirrored that of men.

Substance abuse treatment for women was largely ignored prior to the 1970s, and it was not until that decade when any substantial inquiry was conducted in regard to gender differences. Around this time, former First Lady Betty Ford publicly admitted her long-running battle with alcoholism. She later founded the famous residential treatment center that bears her name.

Various incorrect beliefs persisted into the 1980s. For example, it was still widely believed that compared to men, substance abusing women were better able to hide their disorders and more promiscuous as a result of their disorders. And funding for programs specific to women was less available.

Nevertheless, from the 1970s through the early 1990s, it became apparent there were issues in the treatment of women that were less likely to apply to male clients. For example:

- Childcare was finally being recognized as a barrier to treatment for women,
- Fetal Alcohol Syndrome became recognized as a public health issue, and
- It became increasingly clear that women with addictive disorders were far more likely to have a history of physical and/or sexual abuse than men, and that the related trauma was often a precursor to their addiction.

A turning point came in 1992 when the Substance Abuse and Mental Health Services Administration (SAMHSA) helped fund the establishment of eleven residential treatment programs for women. Although much more progress is needed, there has been in recent years a considerable increase in the number of gender-specific programs for women and a substantial increase in the amount of research focused on substance abuse and treatment for women.

## ***Section II - Engaging Women in Treatment***

Deterrents for women who consider engaging in substance abuse treatment include childcare needs, transportation problems, fear and shame. Even though more women enter treatment today than in the past, there is still a significant

difference in how women with substance abuse disorders are seen in comparison to men. Substance abusers of both genders experience shame, but men who seek treatment are subjected to less stigma than women.

This is primarily due to how society tends to see women's substance abuse as it is believed to relate to their sexual and relationship behavior. And as a practical matter, women may face additional consequences for seeking treatment if they have custody of their dependent children.

### **Barriers to Treatment**

There are several levels at which women may experience themselves as unable or unwilling to contemplate treatment.

One level is intrapersonal, which involves the individual's willingness to see herself as a person with a substance abuse problem for which she needs intervention. A component of the disorder is denial, a consistently reported part of any substance abuse history. For women, particularly if they have children, admitting a substance abuse problem can be equivalent to admitting failure as a partner or mother.

This is particularly true since the issue of drug/alcohol use during pregnancy has arisen as a criminal justice issue in various jurisdictions nationally. Women may engage in many versions of rationalization and minimizing in order to separate their image of themselves as "good" partners and parents from the self who uses alcohol or drugs.

Women may also experience interpersonal barriers to treatment through the context of primary relationships. This can be the most complex deterrent to treatment-seeking for many.

Research indicates women are more likely to have begun use of drugs or alcohol due to trauma, often experienced through primary relationships with either parents or partners. When women are involved in a primary relationship with a partner who abuses substances, this person may use physical or emotional violence as a means of control.

When physical, sexual, or emotional violence is used against children, the woman may perceive her presence in the household as the only barrier against more abuse of the children. The woman may also fear the removal of her children

from custody by outside agencies. Studies of domestic violence often show that the time with the most potential for violence is when the woman leaves the relationship.

Thus, leaving the family to enter treatment can involve trauma and danger. Often, the woman's substance use is influenced by their primary partner's drug or alcohol use, and thus drug abuse becomes integrated into the existing relationship.

In cases where the primary relationship is with a drug dealer, or the home has become a site for methamphetamine production, escape becomes even more difficult. The woman's primary financial subsidy could be based on sale of substances and her significant other may fear she'll "snitch" and get him in trouble with the police.

In any case, women may feel a greater degree of unpleasant exposure and denigration than do men, since the community may view substance abuse disorders as primarily due to immoral behavior rather than physical health.

It may also be that the population in general reacts excessively to the effects of drug use on the community, and particularly on children. An example of this is the strong national response to media coverage about "crack babies" and the dramatically politicized solutions that followed. Even though research now indicates the health consequences of crack use by pregnant women has no worse outcome than cigarette smoking, and may be less damaging to the fetus than alcohol, the stigma remains for pregnant women.

Finally, the affordability and accessibility of treatment may affect the odds of women's participation. They may have difficulty with child care and reliable transportation. If residential treatment is needed, the treatment facility may need to provide services for children as well. Other resources may be necessary, including additional treatment for other addictive behavior, such as eating disorders, or trauma, and co-occurring disorders.

Issues such as these can make appropriate treatment for women quite multi-faceted, but hard to provide with available funding. But generally, appropriate treatment for women must provide for a wider range of services.

### **Outreach Strategies**

Education and an active recovery community can enhance the potential any

individual will choose treatment. Providing detailed information about available resources through schools, treatment agencies, and health facilities will matter.

If there is strong local support for treatment rather than punishment, the level of shame and fear experienced by women is more likely to decrease. It is also necessary to have strong law enforcement and court support for treatment and for domestic violence interventions. The emergence of drug courts has made it possible to meld treatment with law enforcement, and the active role of court personnel in client support may enhance positive outcomes.

Communities with a more comprehensive array of individual and family therapy, group therapy, outpatient, intensive outpatient, residential programs, and aftercare have the best potential for use by a variety of client groups.

When the potential female client is in denial, but there is strong family desire for her to engage in treatment, along with strong family support, direct intervention and engaging in outpatient treatment may work well. This would require a safe, supportive home environment in which the spouse/partner and other family members treat the issue as a health problem, and an issue involving the whole family, so that the disease process is understood as effecting the whole group rather than the patient only. For a successful intervention, it may be helpful to obtain services from a treatment agency.

On the other hand, when the potential female client lives in an unsafe home, and the primary barrier to treatment is either personal abuse or the abuse of children, outreach may involve alternatively a safe, affordable residence, possibly with facilities for children. It is often necessary for women to seek a shelter directed at domestic violence before treatment or evaluation for substance abuse can occur. This is even more difficult if the client is substance-dependent and the provider of the drugs is in the family. In such cases, a well-publicized, reliable and safe crisis hotline may be needed to encourage the person to contact anyone. Engaging the person in treatment may depend on a single phone call.

In general, treatment for women is more effective if the treatment is gender-specific, and all clients are female. This is particularly true when there is a lack of family stability, family support, or household safety.

It is helpful, particularly for women, when treatment agencies sponsor and provide education around issues such as general physical and financial health. A reason women do not engage in treatment frequently is complete financial

dependence on another person or persons, from whom independence seems impossible. Encouraging adult education is an important community factor in terms of increasing the opportunities people can become independent.

### **Addressing Issues Related to Stigma**

Dr. David Rosenbloom says this about stigma: "In many ways, hiding a drug or alcohol problem is the rational thing to do, because seeking help can mean losing a job or medical insurance, or even losing your child when a social service agency declares you an unfit parent".

Hence, it is helpful for women to have models of successful recovery with whom they can identify. Betty Ford is the best-known example of this. Her public identification of herself as a recovering person and her public support for treatment boosted the American treatment community greatly, with other well-known women following. Stigma is decreased when an active community of successfully recovering people can be accessed, who demonstrate through daily living their success in recovery. In addition, it is helpful when the community in general, including those who do not suffer from addictive disorders, can be seen to support recovery efforts.

Women who have been maltreated either physically or emotionally may believe their drug or alcohol use made them "deserve" this treatment. This may be reinforced by belief systems in the community. Victims of sexual abuse are consistently blamed for their treatment, and poor choices with substance use make a handy rationale. It must be clarified that misuse of substances is not in any way an adequate explanation for abusive behavior by others. It is helpful when other survivors of abuse can reiterate this statement. Professionals in the field must be adequately trained in dealing with this particular stigma experienced by women, and individuals who are unwilling or unable to adapt to new thinking may not be viable workers for female clients.

Individuals and organizations who question the equality of women in terms of civil rights and equal partnership should not be encouraged nor permitted to provide treatment services, since adapting to self-sufficiency is a necessary element of the recovery training clients often need to be successful. This may be an issue in some ethnic and religious groups.

Since financial self-sufficiency is often a barrier to treatment-seeking, the appropriateness of women providing their own financial stability may need to be

emphasized. If women have available complete financial support it should be clear this option includes complete personal and emotional safety. If it does not, women may need to be encouraged to pursue other options.

Treatment programs can also counter stigma by providing additional services for the family of the client. The family should be encouraged to engage in the recovery process, and the roles of family members in relapse prevention should be emphasized.

### ***Section III – Assessment for Women***

As a result of developments in the field, appropriate assessment for women today includes comprehensive data gathering in many areas of the client's life. To focus only on substance abuse will not offer enough information to make an appropriate referral.

Thus, the first step is to provide the client with an atmosphere where she feels safe, and therefore more likely to divulge information truthfully and fully. This is especially true if the client is a mother of young children, since she will fear the potential of losing custody if she is found to be abusing substances.

A comprehensive assessment should include the following:

#### Substance abuse/dependency

- The client's belief about the significance of her current substance use
- Her history of substance use in detail, including any treatment history. It is important to include information about any periods of successful abstinence and why the client believes she was able to do this.
- How/where the client obtains substances and how she pays for it.
- Factors influencing the client's decision to seek treatment

#### Medical & mental health history

- History of infectious or contagious diseases and related treatment history
- General health and dental history, including any current problems. It is important to note any chronic pain, for which medication may be prescribed but inappropriately used or abused.
- History of mental health issues and/or treatment. If mood disorders appear

to be present, try to establish whether the mood disorder preceded or followed substance abuse. Clinicians should also screen for behavioral disorders such as gambling or sexual addictions.

- History of sexual, physical, or emotional abuse, and any history of violent behavior.

### Social history

- Family history and social roles in which the client has functioned, current and past.
- Involvement in the criminal justice system by client and family.
- Educational and vocational history and needs.
- Involvement with spiritual activities
- Support from family and friends.
- History with domestic violence and child neglect or abuse
- Ethnic/cultural issues of potential relevance to treatment

And, of course, where the assessment is taking place will have some influence on how it is conducted. For instance, a woman with a substance use disorder may show up at a mental health center if she perceives depression to be less stigmatizing than substance abuse.

## ***Section IV – Treatment Participation & Approaches***

### **Choosing the Course of Treatment**

Defining the primary immediate problem is necessary to make an appropriate treatment referral. The client may need immediate intervention into her use of substances; may be using substances primarily due to a mental health disorder, or may be in need of treatment for a co-occurring disorder.

The client may not be helpful in making this determination because she may regard some disorders as more “acceptable” than others (though of course, the client may view having no disorders as the most acceptable outcome of all). Particularly for female clients, having a mental health issue such as depression is more palatable than having a substance use disorder, since substance abuse could have consequences ranging from stigma to loss of parental rights.

Moreover, the client may view some substances as “worse” than others, so

it is also helpful to obtain a drug screen during the assessment or treatment planning phase if possible.

Counselors should determine right away whether client first needs detoxification or hospitalization. It should also be determined whether suicidal ideation is present and whether the client has a plan and intends to act on it. If so, involuntarily hospitalization may need to be the clinical intervention.

Obviously, the next step beyond detoxification will be determining what level of treatment the client needs. If residential treatment is necessary, the client may be placed on a lengthy waiting list, which is likely to happen with a publicly funded program.

If the safety of the woman or her children is a concern, they may need to be housed in a domestic violence shelter until a residential treatment bed is available. Otherwise, clients waiting for a residential bed should be engaged in outpatient treatment if the home environment is relatively safe and supportive.

Intensive outpatient or even non-intensive outpatient treatment is an option for clients who have difficulty establishing an initial period of sobriety, but who generally have enough family and peer support to successfully remain in the community. And of course, while determining the best course of treatment, clinicians should consider the need for family therapy, mental health/psychiatric assistance, and other types of social services.

### **Counseling Women Who Abuse Substances**

As mentioned previously, women tend to benefit more from gender-specific programming, and this is especially true with the more intensive levels of intervention found in residential substance abuse treatment and in a therapeutic community (TC).

Approximately 1.4 million children under 18 live with a substance dependent mother in a single-parent household usually headed by a mother.

Hence, women's residential programs can better serve their communities by offering beds for their clients' children. Programs that offer this appear to do a better job of offering valuable adjunct services. The 2007 SAMHSA National Survey of Substance Abuse Treatment Facilities found that residential programs with children's beds were more likely than facilities without such beds to provide

services such as case management and social skills development. Plus, mothers are more likely to successfully complete a long-term residential treatment program when they have their children with them.

As is true of treatment in general, the length of stay in a residential treatment program is positively correlated with better outcomes. Giving female clients some latitude with their length of stay is crucial, especially since pregnant or nursing clients may need several months to successfully make the transition from a controlled environment to the community.

Therapeutic communities (TCs) are long-term residential programs where peer influence and peer mentoring assume a more prominent role than they normally do in a traditional residential treatment model. As residents advance through each stage of a TC, they usually acquire more privileges and responsibilities, and are expected to eventually serve as a peer mentor/leader for new residents.

In a TC, professional staff may be fewer in number and serve in more of an advisory role to allow positive peer influence to take hold. Plus, it is important to note that some residential recovery programs using a social model are not licensed substance abuse treatment programs. However, the social model used by The Healing Place in Louisville, Kentucky has been nationally recognized and has been replicated by numerous agencies. So clinicians are advised to definitely consider such a program along with other options when working with clients.

Research indicates that participation in a TC is associated with positive long-term outcomes, but TCs also have high dropout rates. This is not surprising when considering that clients may be harder on each other than professional counselors might be. Hence, professional staff must avoid being hands-off to the point where “inmates run the asylum” yet avoid the temptation to control the group’s dynamics to the point of thwarting the purpose of a TC.

Successfully retaining clients is an issue for any type of treatment, though. A few studies have found that women stay in treatment longer than men, but the majority have revealed that it is actually men who tend to stay in treatment longer. Studies have generally found the following factors to be associated with women staying in treatment longer:

- Age. Older clients tend to stay in treatment longer, although some studies have found this is an unreliable indicator.

- Higher level of educational attainment. Women who did not finish high school are more likely to leave treatment earlier than high school graduates.
- Belonging to racial or ethnic groups other than African American.
- Criminal justice system involvement. Women referred by sources other than the criminal justice system are more likely to leave treatment prematurely.
- Receiving treatment at women-only programs.
- Having a payment source for service other than private health insurance. Presumably, this is partly due to the severe limits many private insurers place on coverage for counseling of any sort.

Ideally, counseling services for women should be based on empowering them to be more independently functional (especially if they are in an abusive relationship) while also facilitating their need to affiliate with others. Researcher and writer Stephanie Covington suggests a “relational model,” in which she sees the primary developmental motivation as establishing a strong sense of connection with others. In other words, counseling should focus on establishing a strong sense of self and a strong sense of relationship with others.

Following are some considerations for various types of services:

Psychoeducation: Many intensive, structured treatment programs use psychoeducation classes as a way to impart information to clients about a variety of topics. Such classes are more likely to be effective with women if they are provided an opportunity to discuss women’s issues and to generally process the information received at greater length than a men’s group typically would.

Individual and group psychosocial treatment: Research indicates that women respond well to both guidance and counseling. Since women often began abusing substances to avoid painful emotions, clinicians should use their skills to help their clients address issues on both a cognitive and an affective level. As is the case with psychoeducational groups, counselors should provide female clients with a safe, interactive environment in which to process issues.

Pharmacological approaches: Research consistently indicates that methadone maintenance effectively reduces withdrawal symptoms and craving for clients who abused opiates. Methadone maintenance is vital for pregnant women addicted to opiates because of the danger withdrawal poses for the fetus. Women with additional diagnoses such as bipolar disorder or major depression may need to remain on psychiatric medication to increase the likelihood they will

remain in treatment.

Non-traditional approaches can include, but not necessarily be limited to yoga, meditation, acupuncture, and relaxation techniques.

Think twice before dismissing such approaches as “fluffy.” Yoga has been integrating the mind, body, and spirit of its participants for 5,000 years. The deep breathing techniques used in yoga oxygenate the body better than regular chest breathing, which is important for people whose bodies have suffered from long-term addictions. Although yoga and meditation are often practiced with a spiritual intent, they do not necessarily have to be practiced with such an intent.

### **Self-Help Groups and Women**

Women were not initially welcomed into Alcoholics Anonymous because of the stigma surrounding female substance abusers. However, today, an estimated one out of three members of Alcoholics Anonymous is a woman.

Does involvement in 12 Step groups such as Alcoholics Anonymous and Narcotics Anonymous help women? In general, the answer appears to be yes. 12 Step group involvement, even when considering the impact of length of stay in treatment, is associated with higher levels of abstinence and decreased amounts of substance use. Self-selection could account for some of these results (i.e., 12 Step participants were more motivated to stay sober in the first place as compared to those who attended less or not at all).

Nevertheless, research suggests that assistance from peers plays a very important role in recovery and that one important predictor of peer helping is being female. In other words, when given the chance, female 12 Step participants are more likely than male participants to display pro-social, helping behaviors toward other self-help group members.

However, 12 Step groups are not effective or appropriate for all clients. Female clients sometimes feel uncomfortable sharing “character flaws” and personal information in meetings where men are present. Plus, some clients and professionals are uneasy with the emphasis on admitting powerlessness when female alcoholics and addicts (particularly low-income women) often feel powerless anyway.

For women, one alternative to 12 Step groups is Women for Sobriety (WFS),

a secular recovery group for alcoholic women established by sociologist Jeanne Kirkpatrick after she was unable to maintain sobriety in AA. At the core of WFS is the “New Life” program, which is based on the following 13 affirmations:

- 1) I have a life threatening problem that once had me.
- 2) Negative thoughts destroy only myself.
- 3) Happiness is a habit I will develop.
- 4) Problems bother me only to the degree I permit them to.
- 5) I am what I think.
- 6) Life can be ordinary, or it can be great.
- 7) Love can change the course of my world.
- 8) The fundamental object of life is emotional and spiritual growth.
- 9) The past is gone forever.
- 10) All love given returns.
- 11) Enthusiasm is my daily exercise.
- 12) I am a competent woman and have much to give.
- 13) I am responsible for myself and my actions.

Like AA, Women for Sobriety encourages openness and sharing. Unlike AA, the group focuses on improving self-esteem rather than acknowledging powerlessness. Due to the emphasis on positive thinking, discussions about past drinking experiences are discouraged.

Self-help groups of a secular nature available for both men and women include SMART (Self Management and Recovery Training) Recovery and Secular Organizations for Sobriety (SOS). SMART Recovery promotes viewing addiction as a dysfunctional habit, as opposed to a disease, and offers a science-based approach using behavioral and cognitive methods. SOS is a network of autonomous recovery groups that emphasizes rational decision making.

Conversely, there appears to be an increasing number of self-help groups of an explicitly religious nature. For example, Celebrate Recovery, which originated in the Saddleback Church in California, adapts the 12 Steps of Alcoholics Anonymous to specifically fit Christianity. In addition, the group aims to address mental health issues of all kinds and stresses eight Recovery Principles based on the Beatitudes. In order to be comfortable in and derive the most from the program, acceptance of the Christian faith is necessary. Hence, it is more unlikely than A.A. to be comfortable for persons of other faiths or to agnostics or atheists.

## Treating Women With Substance Use and Eating Disorders

Women with substance abuse or chemical dependency disorders often present with eating disorders, too. These disorders may interlink, with one precipitated in whole or in part by the other. For instance, clients may have begun using substances to lose weight and, in the process, became addicted and obsessed with body image at the same time.

Having both disorders can increase the variety of physical and emotional problems experienced as the result of use and abuse which, in turn, may impact the client's chance for recovery. Plus, eating disorders may be harder to identify than they already are when a psychoactive substance use disorder is present.

The three most common disorders are anorexia, bulimia, and binge eating. They are more likely to occur in women, although the number of men with such disorders is increasing. About one in five women can either be diagnosed with an eating disorder or engages in disordered eating that falls short of diagnostic criteria. And an estimated one million U.S. men suffer from eating disorders.

A cultural emphasis on achieving "perfect" appearance has increased the potential for women and girls to be obsessed with body image and to be more susceptible to sales pitches for makeup, plastic surgery, and so on. Since the images projected are nearly impossible to achieve, the discomfort girls feel with their bodies now begins before adolescence. The conflicting extremes of discomfort with the body and the desire for an altered one result in eating disorders, through which extremes of control are sought by individuals who suffer from these diseases. This may include an inability to accurately appraise one's own body size, and a significantly altered view of one's appearance.

Anorexia nervosa is an extreme effort to control weight by under-consuming food. Women who have this disorder are very thin, but believe they are overweight. Persons with this disease are in a process of starvation, and if the disorder is not treated successfully, the patient will die. Hence, restoring the client to a healthy weight is the primary initial treatment goal.

Bulimia nervosa is characterized by "binge-purge" behavior. The person will engage in binge-eating, then compensate by purging the excess food through induced vomiting. Persons with this disorder are more difficult to identify because they may appear normal in terms of body weight. However, they are likely to have throat problems, digestive problems, problems with teeth, or

electrolyte imbalances. Generally, the preferred treatment approach is medical monitoring accompanied by cognitive-behavioral therapy.

Binge-eating disorder is characterized by episodes where the client binge-eats without the attempt to purge. As a result, these clients are often obese. Like bulimia, the client experiences a loss of control over eating, sometimes accompanied by a dissociative state in which there is no effort to control behavior. Treatment is similar to that used for bulimia.

There are also less common disorders such as body dysmorphic disorder, where small or imagined body flaws become obsessions.

Women with co-existing eating disorders and substance abuse disorders are more likely than men to have developed such problems as a result of trauma. When a client in treatment for substance abuse is also diagnosed with an eating disorder, the first step, as always, is to determine what steps are medically necessary to ensure safety.

After this goal is reached, it is important to assess the degree to which the client's drug use and eating disorder are connected, such as whether the client used drugs to control her weight or whether compulsive eating was a substitute when drugs were not available. It is also important to determine whether food use relates to economic circumstances, such as poverty to the point of starvation or using income to buy drugs instead of food.

Because each client's history is unique, it is important to construct a treatment plan specifically addressing that history. Clients may under-report or deny eating disorder symptoms out of shame. One possible way to address the topic is to initiate discussion about cultural expectations for women's appearance and about health in general.

The goal of health should not be confused with the goal of improving appearance. Counselors should give general information only around diet and exercise rather than to endorse a specific set of instructions, unless the clinician has expertise in this field. An overemphasis on certain kinds of food can result in disordered eating (such as a vegan diet carried to extremes) and each client must decide on an exercise program that will work within her abilities or budget.

## *Section V – Special Populations*

### Pregnant Women

The risks associated with substance use during pregnancy, particularly alcohol and tobacco use are well documented and will not be revisited in detail here. Risk factors for substance use during pregnancy vary by substance but may include pre-conception use of the substance, continued use by a partner, lack of social support, and unplanned pregnancy.

Fortunately, the provision of chemical dependency treatment to pregnant women is associated with positive outcomes such as reduced substance use, reduced risk for contracting HIV, and better birth outcomes. Even more abbreviated and focused interventions make a significant difference. One study found that a brief, 5-session motivational intervention with pregnant women who drank to excess reduced the risk of alcohol use twofold during pregnancy. Another study found that a brief motivational intervention conducted by a nutritionist over a few sessions appeared to decrease alcohol consumption during pregnancy.

For pregnant women who are physiologically dependent, inpatient detoxification is required. Detox should be followed by coordinated follow-up with a primary care physician, obstetrician, and addiction specialist.

Currently there are no FDA approved psychopharmacological treatments for alcohol, nicotine, marijuana, or amphetamine dependence among pregnant women. Methadone maintenance is FDA approved for women who have opioid dependence, though.

Women on methadone maintenance may report withdrawal symptoms on their maintenance dose after they are pregnant, and may need a dose adjustment. Women who use other opioids, especially intravenously, should be considered for methadone maintenance during pregnancy in order to minimize the risk of withdrawal cycles, spontaneous abortions, and infectious diseases.

Like any other psychoactive substance, cocaine can potentially have significant harmful effects on the fetus and on the mother. However, cocaine withdrawal is not necessarily life threatening for the mother or fetus, and the associated mood symptoms may be treated with a variety of medications.

## Racial/Ethnic Minority Women

Substance use is influenced by the cultural norms and practices of the ethnic group(s) to which they belong, in addition to biological, psychological, and other social factors. Furthermore, perceptions of discrimination have been linked to higher levels of psychological distress and poor health outcomes.

However, bear in mind that a considerable amount of diversity thrives within any racial or ethnic minority population. In other words, the group's characteristics are general as opposed to absolute, and do not necessarily apply to all individuals or even a majority of the group's members. Plus, in a treatment context, individual clients may struggle against biases they experience within their cultural group (for example, an African-American client with speech and mannerisms the other African-American clients regard as being "white"). So clinicians must not assume that a client's membership within a group means the client will necessarily have the same set of issues as other similar clients.

Yet, in order to successfully treat a client, counselors must first establish an effective relationship. The degree to which the counselor succeeds in this regard depends partly on cultural competence. As such, counselors are ethically obligated to engage in the appropriate training needed to establish familiarity with particular client populations.

A helpful guide for establishing cultural competence, originally developed by Cross et al (1989), is outlined in the Treatment Improvement Protocol 46 from SAMHSA. Here, six stages of cultural competence are described, as follows:

Stage 1: Cultural Destructiveness. People in this stage demand that others assimilate to a certain culture and fit the pattern of that culture.

Stage 2: Cultural Incapacity. Those in this stage lack the capacity or will to help minority clients in the community. This person applies resources unfairly and may even see segregation as desirable.

Stage 3: Cultural Blindness. Here, professionals believe that race and culture make no difference because all people are the same. Not surprisingly, people in this stage tend to favor assimilation while ignoring the strengths of various cultures.

Stage 4: Cultural Pre-Competence. A counselor in this stage may lack

information or may be unsure how to proceed, but generally realizes his/her weaknesses and desires to deliver quality services to minority populations.

Stage 5: Cultural Competence. The counselor shows acceptance of and respect for differences and actively expands his/her knowledge of other cultures and related resources.

Stage 6: Cultural Proficiency. Persons in this stage hold all cultures in high esteem while continuing to add to their base of knowledge.

Although this model was designed as a tool for administrators to assess their own organizations, counselors can – and should – use it to examine their own competencies with particular populations. This continuum can also be used as a guide for suggesting training topics for individuals or whole organizations.

With this in mind, minority women may experience discrimination on more than one level (minority + woman + substance abuse + other factors). As a result, “escapism” alcohol and other drug use may be more commonly seen among minority women than among non-minority clients.

For example, in a qualitative study, African-American women revealed that substance abuse was a way to neutralize painful feelings associated with the loss of loved ones, racism, discrimination, and histories of abuse. The author of this study suggested a “cultural care model” for African-American women that would include helping them resolve psychological distress and co-existing depression by creating meaning in social, religious, and cultural ways. Indeed, research indicates that African-centered principles such as spiritual faith and interconnectedness serve as protective factors against anxiety, depression, and other challenges that may trigger relapse.

Counselors should assess whether minority women are struggling with the loss of cultural values and indigenous ways of life and being, since any loss of ethnic identity and cultural knowledge may cause distress. Such issues can be particularly salient for Native American women or urban Appalachian women.

With Hispanic/Latina clients, counselors should be aware of the wide range of diversity within this broadly defined group. “Hispanic” clients may be new immigrants or 1<sup>st</sup>, 2<sup>nd</sup> or 3<sup>rd</sup> generation...may speak no English...may speak no Spanish...and could potentially be multi-racial.

The degree of acculturation to the majority Anglo-Saxon culture should be considered as well, since a greater degree of acculturation and education among Hispanic women is associated with substance abuse (this also appears to be the case with Asian-American women as well).

### **Appalachian Women**

Although the general public tends to view the mountainous areas of Kentucky, West Virginia, and Tennessee as the geographic and cultural hub of Appalachia, the federal government defines Appalachia as 420 counties in 13 states stretching from New York to Mississippi. Plus, as a result of the large, sustained 20<sup>th</sup> century migration from rural Appalachia into various urban centers (Cincinnati, Detroit, and Cleveland, to name just a few), the influence of Appalachian culture has also taken hold outside of the federally defined region.

More detailed information about Appalachian culture as it relates to substance abuse treatment can be found in our home study course “Cultural Considerations in the Provision of Substance Abuse Treatment for Appalachian Clients,” also published by Heisel and Associates. For the purposes of this course, though, we will note the following.

Female clients in general may face barriers to treatment such as transportation, inability to pay fees, unsafe or unstable housing, and childcare. However, in rural areas and in Appalachia in particular, these may be especially daunting obstacles to getting help.

Transportation and less anonymity are believed to be reasons why fewer Appalachian women participate in recovery support groups such as Alcoholics Anonymous and Narcotics Anonymous. In their review of Appalachian programs, the University of Kentucky found that only 23% of women served in the time frame studied had an Alcoholics Anonymous or a Narcotics Anonymous sponsor, in comparison to 39% of women in non-Appalachian programs. Plus, beliefs related to fatalism, self-sufficiency, and distrusting outsiders can be potential barriers to accepting treatment.

Including storytelling as a component of group treatment is becoming popular in Appalachia and has been the subject of research conducted by the University of Kentucky Center on Drug and Alcohol Research.

Otherwise, it appears that the most promising approaches and

interventions for women in general are applicable to Appalachian women. These include helping clients strengthen their self-esteem and to attain a level of trust in themselves they previously did not possess.

### **Sexual-Minority Women**

Perhaps the biggest challenge facing the addiction field in regard to sexual minority women is the inherent diversity within this population

Sexual-minority women are more likely to drink and use drugs more heavily, and are more likely to experience problems related to their use than heterosexual women. Tobacco use is also much higher in sexual minority women compared to heterosexual women. Discrimination, higher stress levels associated with their minority status, and the relative lack of support for same-sex relationships appear to be factors. Another exacerbating factor is the large numbers of social outlets in the gay-lesbian community where alcohol and drug use are common.

Despite these barriers, it appears that sexual-minority women seek treatment at higher rates than heterosexual women. Sexual orientation should never be ignored and counselors should never assume clients are heterosexual.

### **Women with Co-Occurring Mental Health/Psychiatric Disorders**

Compared to men, substance abusing women are more likely to present with co-occurring major depression or other Axis I disorders. In fact, women with a substance use disorder are more likely to have primary, as opposed to secondary depression and are more likely to score higher on the Beck Depression Inventory than men. The high prevalence of mood and anxiety disorders among women who abuse substances indicates a strong need for a thorough assessment of each client's mental health status and history.

Treating women with co-occurring substance use and mood disorders can be complicated and difficult, but there are some promising approaches. For example, cognitive behavioral therapy and other approaches that can be specifically tailored to address both mood and substance abuse have better outcomes than less specific treatments.

Women who abuse substances are twice as likely to have anxiety disorders than are men. Women with both problems may present with more somatic

complaints than men with both disorders.

A number of women in treatment for substance use have experienced violence and trauma that began in childhood and has continued in some form into adulthood. Not surprisingly, post-traumatic stress often precedes the onset of substance abuse in women, which ends up being a form of self-medication. A combination of psychiatric medication and therapy may be considered for clients with co-existing substance use and post-traumatic stress disorders.

Personality disorders, particularly Cluster B disorders such as Borderline Personality Disorder, are common among women who abuse substances, which often results in a more complicated, difficult course of treatment and requires an ongoing evaluation of the client's potential for suicide. In general, treatment approaches that are structured and focused on improving coping skills appear to have a better chance of success.

### **Female Offenders**

Women comprise 14% of violent offenders, 22% of all arrestees, 16% of convicted felons, and 10% of the corrections populations. Although women still comprise a small portion of the criminal justice population, the number of women convicted of felonies in state courts since 1990 has grown at more than twice the increase in the male population.

Not surprisingly, alcohol and other drugs are a factor behind this growth. One-half of women in state prisons were using both alcohol and drugs at the time of offense, with 25% being daily drinkers. They are also more likely than men to enter correctional facilities at a more advanced stage of drug abuse than men. Adult male offenders are twice as likely as women to have juvenile records, but women were far more likely to have been crime victims as juveniles.

More than 70% of incarcerated women are mothers, and many women in the criminal justice system have unstable work histories, no work history, or a legal or illegal background in sexually oriented businesses. Not surprisingly, a study by the National Institute on Drug Abuse found that women offenders, in comparison to men, are more likely to be mentally ill and to have employment and child-rearing issues while in custody or under supervision.

Women who are coerced into treatment may seem more likely to have poor treatment outcomes than non-offender females, but this is not necessarily the case.

Criminal justice system involvement is actually associated with longer stays in treatment, even if the criminal justice system was not the primary referral source for counseling.

A number of substance abusing female offenders have criminal thinking patterns and values. Although there are no known thinking error interventions designed specifically for women, various programs have incorporated existing material of this sort into their treatment curricula. Often, women's crimes are committed in relation to their significant others – yet another reason why it is important to help female clients examine the effects of their relationships.

### ***Section VI – A Recovery Revolution?***

In closing, there are exciting new developments in the substance abuse treatment and recovery communities that have positive implications for everyone affected by addiction, and perhaps especially for addicted women.

For many years, the chemical dependency treatment profession has specialized in providing time-limited acute care where families, faith leaders, and other community allies have not been invited into the recovery process to the extent they should be. Yet, chemical dependency is a chronic disease that requires intervention and follow-up over a long period of time.

This is why a growing number of experts are saying, as quoted in a recent monograph on this topic, “Significantly improving long-term treatment outcomes will require a radical re-engineering of addiction treatment as a system of care.” In other words, a paradigm shift is underway where the addiction treatment field:

- Supplements acute care with a long-term focus where families, persons in recovery, and many other sectors of the community are integrated into the recovery process;
- Builds on the personal responsibility and strengths of individuals, families, and the communities to achieve health, wellness, and recovery from substance abuse; and
- Shifts the question from, “How do we get the client into treatment?” to “How do we support the process of recovery within the person’s environment?”

This kind of transformation from individual professional silos (mental health, substance abuse, etc.) into a more cohesive and community-based “recovery oriented system of care” is well underway in places like Philadelphia. With extensive input from recovering people and their families, the behavioral health care system in Philadelphia is now characterized by closer partnerships between various agencies; outreach efforts devoted to removing as many obstacles as possible; making service providers more focused on client retention and less so on admission criteria; and offering clients more choices rather than specific prescriptions for change.

This movement is also characterized by an increased emphasis on the type of peer-to-peer assistance associated with the social model (described in Section IV) and on shifting much of the actual service delivery from institution-like settings and into the neighborhoods, and even into the homes of recovering individuals and their families.

So what does this mean for addicted women? Transforming a behavioral health care system in this way requires a certain amount of advocacy on behalf of recovering individuals which - if done successfully - will reduce the stigma faced by addicted women. This also requires generating community involvement in the form of cultivating closer relationships with local self-help groups or starting mentor programs that benefit clients.

Other geographic areas are making this transformation to one degree or another and funding sources such as the Substance Abuse and Mental Health Services Administration (SAMHSA) are providing grants for this purpose. If such a transformation is implemented with input from the recovery community and careful planning, it can only benefit women in the long run.

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## Counseling Women Who Abuse Substances

Please Print Clearly or Type:

Name: \_\_\_\_\_

License #: (Psychologists only) \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Work: \_\_\_\_\_ Home: \_\_\_\_\_

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MasterCard \_\_\_ Visa \_\_\_ Expiration Date: \_\_\_\_\_

Card Number \_\_\_\_\_

Billing Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## Post-Test Questionnaire

1. What number of drinks per week exceeds the dietary guidelines issued by the U.S. Department of Health & Human Services and the U.S. Department of Agriculture?
  - a. 14
  - b. 7
  - c. 20
  - d. 10
  
2. Compared to men, women are 48% more likely to be prescribed a narcotic, an anti-anxiety medication, or a potential drug of abuse.
  - a. True
  - b. False
  
3. Compared to men, women tend to develop alcohol-related liver disease and liver, brain, and heart damage more quickly.
  - a. True
  - b. False
  
4. Women have lower levels of \_\_\_\_\_, a chemical that breaks down alcohol in the digestive system before it moves into the bloodstream.
  - a. liver enzymes
  - b. nucleus accumbens
  - c. alcohol dehydrogenase
  - d. serotonin
  
5. The percentage of women who drank alcohol rose as high as 66% in \_\_\_\_\_.
  - a. 2005
  - b. 1969
  - c. 1981
  - d. 1975
  
6. Women get about the same levels of alcohol in their system and don't become any more impaired than men after drinking an equivalent amount of alcohol.
  - a. True
  - b. False
  
7. Why was past media coverage about "crack babies" so misleading?
  - a. Subsequent research indicated that crack use by pregnant women had no worse effect on the fetus than cigarette smoking by pregnant women
  - b. Media coverage implied that the incidence of pregnant women smoking crack was much higher than it actually was.

- c. Nothing was misleading about the media's coverage of "crack babies."
  - d. None of the above.
8. Which of the following is a potential obstacle to women seeking or getting substance abuse treatment?
- a. A spouse who abuses substances or sells drugs.
  - b. Childcare
  - c. The stigma surrounding substance abuse
  - d. All of the above
9. Which of the following statements about therapeutic communities is false?
- a. Therapeutic communities may or may not be licensed treatment programs
  - b. Peer influence and peer mentoring may have a more prominent role in a therapeutic community, as compared to a traditional residential treatment program.
  - c. When in doubt, professional staff should err on the side of "letting the inmates run the asylum."
  - d. All of the above statements are true.
10. The 2007 SAMHSA National Survey of Substance Abuse Treatment Facilities found that residential programs with children's beds were more likely than facilities without such beds to provide services such as case management and social skills development.
- a. True
  - b. False
11. Therapeutic communities are associated with positive outcomes and have relatively low dropout rates.
- a. True
  - b. False
12. Compared to heterosexual women, sexual minority women are \_\_\_\_\_ to enter substance abuse treatment.
- a. More likely
  - b. Less likely
  - c. Equally likely
  - d. None of the above
13. The author of a qualitative study suggested a \_\_\_\_\_ model for African-American women that would include helping them resolve psychological distress and co-existing depression by creating meaning in social, religious, and cultural ways.
- a. Diversity enhancement

- b. Cultural care
  - c. Cultural enlightenment
  - d. None of the above
14. Which of the following statements is false?
- a. Methadone maintenance is not safe for women who are pregnant.
  - b. Even brief motivational interventions with pregnant women are associated with positive outcomes.
  - c. There are no FDA approved psychopharmacological treatments for pregnant women.
  - d. All of the above statements are true.
15. Professionals believing that race and culture make no difference because all people are the same is an example of \_\_\_\_\_.
- a. Cultural incapacity
  - b. Cultural pre-competence
  - c. Cultural sensitivity
  - d. Cultural blindness
16. Which usually happens first – substance abuse or post-traumatic stress disorder?
- a. Substance abuse
  - b. Post-traumatic stress
  - c. They're about equal in terms of which is likely to come first
17. When a client has a co-occurring substance use and personality disorder, it is particularly important to assess the client's risk for suicide on an ongoing basis.
- a. True
  - b. False
18. There are no known "thinking error" interventions designed just for women offenders.
- a. True
  - b. False
19. Which of the following are associated with women staying in treatment longer?
- a. Age
  - b. Higher level of educational attainment
  - c. Receiving treatment at women-only programs
  - d. All of the above
20. Researcher and writer Stephanie Covington suggests a(n) \_\_\_\_\_, where she sees the primary developmental motivation as establishing a strong sense of connection

with others.

- a. Interconnected approach
  - b. Affiliational model
  - c. Relational model
  - d. None of the above
21. Twelve Step group involvement is not necessarily associated with higher levels of abstinence and decreased substance use.
- a. True
  - b. False
22. Which is an example of an affirmation used by Women For Sobriety?
- a. "Happiness is a habit I will develop"
  - b. "I am responsible for myself and my actions"
  - c. "I admitted I was powerless over alcohol"
  - d. a & b only
23. The number of men who have an eating disorder is \_\_\_\_\_.
- a. Increasing
  - b. Decreasing
  - c. Unchanged from past years
  - d. No reliable data are available regarding this
24. Risk factors for substance use during pregnancy include
- a. Pre-conception use of substances
  - b. Pregnancy was unplanned
  - c. Continued substance use by a partner
  - d. All of the above
25. The most advanced stage of cultural competence is \_\_\_\_\_.
- a. Cultural competence
  - b. Cultural independence
  - c. Cultural proficiency
  - d. Cultural expertise
26. The three most common eating disorders are anorexia, bulimia, and \_\_\_\_\_.
- a. Binge eating
  - b. Body dysmorphic disorder
  - c. Intermittent dieting
  - d. None of the above

27. Which of the following has become a popular component of treatment for women in Appalachia and has been the subject of research?

- a. Sewing
- b. Storytelling
- c. Meditation
- d. Yoga

28. Women in Appalachian programs participate in AA or NA at about the same rates as women in programs outside of Appalachia.

- a. True
- b. False

**I, \_\_\_\_\_ (name of participant) affirm that I am the person who completed this home study and am responsible for this post test.**

**Signature: \_\_\_\_\_**

# HOME STUDY EVALUATION FORM

In the interest of continued improvement, we greatly appreciate your evaluation of this workshop. Please be as specific as possible. Thank you for your assistance.

A: Home Study Workshop: Counseling Women Who Abuse Substances

B: Date Evaluated: \_\_\_\_\_

C. What is your overall evaluation of this home study workshop?

1 2 3 4 5 6 7 8 9 10  
poor average excellent

D. The material was interesting and informative. It held my interest.

1 2 3 4 5 6 7 8 9 10  
strongly disagree neither agree nor disagree strongly agree

E. I feel like I learned something useful to my work.

1 2 3 4 5 6 7 8 9 10  
strongly disagree neither agree nor disagree strongly agree

F. Was the process of accessing our website, downloading the text and sending in the test easy?

1 2 3 4 5 6 7 8 9 10  
no OK yes

G. Would you recommend this workshop to a colleague?

1 2 3 4 5 6 7 8 9 10  
no Maybe yes

Additional Comments:

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