Substance Abuse Treatment for Women

Quantum Units Education
Affordable. Dependable. Accredited.

www.quantumunitsed.com

7 Substance Abuse Treatment for Women

In This Chapter

Overview

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

Treatment Retention

The many factors that influence clients to enter treatment are often the same ones that keep them in treatment. Treatment retention refers to the quantity or amount of treatment received by a client. Today, retention is more likely defined using the term "length of stay," and is measured by months or a timeframe rather than by the number of sessions (Comfort and Kaltenbach 2000; Greenfield et al. 2007*a*). Historically, literature has reflected that treatment duration (retention) has served as one of the most consistent predictors of posttreatment outcome, yet literature remains limited regarding the specific relationship between retention and outcome among women with substance use disorders. (For literature reviews on retention and outcome factors for women with substance use disorders, see Sun 2006; Greenfield et al. 2007*a*.)

Gender is not likely to predict retention in substance abuse treatment. For some time, it has been assumed that women are more likely to leave treatment, but some literature counters this view (Joe et al. 1999). Do women have lower retention rates than men? This is a difficult question to answer because treatment retention often involves the contribution and interaction of numerous variables. Studies have begun to identify these variables and how they relate to each other to influence treatment retention rates among women (see Ashley et al. 2004), but further research is needed to understand the complexity and interactions of these variables.

Psychiatric symptoms, drugs of choice, motivation levels, class, race, ethnicity, criminal justice history, addiction severity, and patterns of use are common factors that typically influence or predict retention among clients in general (see Simpson 1997). Among women, several factors have been identified that influence or predict retention. The following section highlights these factors. Nonetheless, this is not an exhaustive list of retention conditions or issues, but one that is limited to factors that are evident across several studies or that provide some insight into women's issues that need further empirical exploration.

Factors That Influence Retention Among Women

Sociodemographics

Relationships: Support from a partner during treatment and recovery can contribute significantly to long-term maintenance of abstinence. Some treatment studies suggest that including a partner or significant other in a client's treatment also contributes significantly to successful short-term outcomes (Price and Simmel 2002). For example, couples therapy for women in alcohol and drug abuse treatment contributed to favorable outcomes in one study (Trepper et al. 2000), and a study by Fals-Stewart and colleagues (2005) indicates that behavioral couples therapy was associated with abstinence and sustained recovery. Zlotnick and colleagues (1996) also found family therapy to be an effective component for women in an outpatient substance abuse treatment program.

It appears that women who develop relationships in treatment are less likely to successfully complete treatment if their new partner discontinues treatment. In one qualitative study, all of the women who did not successfully complete treatment established a sexual relationship during the early phase of outpatient treatment (Ravndal and Vaglum 1994).

Age: Age appears to be a factor that influences retention. According to the Drug Abuse Treatment Outcome Study (DATOS), age has a significant positive effect on retention in residential treatment (Grella et al. 2000). In a study examining variables associated with retention in outpatient services, women younger than 21 were not as likely to successfully complete outpatient treatment (Scott-Lennox et al. 2000). Likewise, criminal justice research found that women who are older at their first arrest were more likely to complete treatment (Pelissier 2004).

Education: Women with a high school education are more likely to stay in treatment. According to two studies (Ashley et al. 2004; Knight et al. 2001), women who have a high school degree or equivalent are more likely to stay in treatment longer and complete treatment than women with less than a high school education. While education level is influential, it may be a reflection of other client characteristics or socioeconomic conditions.

Women of color: Research typically reflects lower retention rates among women of color. While more research is needed to pinpoint the specific factors that lead to lower retention rates among ethnically diverse women, a key variable appears to be economic resources. According to Jacobson, Robinson, and Bluthenthal (2007), limited economic resources may play a more significant role in retention than specific demographics or severity of substance use disorder.

Criminal justice and child protective services referral and involvement

It appears that either referral or involvement with the criminal justice system or child protective services is associated with longer lengths of treatment (Brady and Ashley 2005; Chen et al. 2004; Green et al. 2002). Specifically, Nishimoto and Roberts (2001) concluded that women who were mandated by the criminal justice system to enter treatment and who also had custody of their children were more likely to stay in treatment longer. While some studies reflect mixed results on the effect of women being mandated to treatment by the court, another study (generated from the sample of participants in the Substance Abuse and Mental Health Services Administration's [SAMHSA's] Women, Co-Occurring Disorders, and Violence Study) found that retention was higher among women who had been mandated to treatment (Amaro et al. 2007).

Pregnancy

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

Pregnancy and co-occurring disorders: Pregnancy often adds to the challenge of retaining clients who have severe psychiatric disorders in treatment. In one study (Haller et al. 2002) that compared retention rates across three groups of women, the group characterized by severe addiction, psychiatric (DSM Axis 1 diagnosis) and personality (DSM Axis 2 diagnosis) disorders had rapid attrition (a 36 percent dropout rate), whereas the groups described as clinically benign or with less severity but with externalizing personality deficits were more likely to complete treatment. In a similar study conducted by Haller and Miles (2004), women with more severe pathology were twice as likely to leave treatment against medical advice. While these studies have limitations, they do shed light on the role of psychiatric issues in retention among women, particularly pregnant women, and the need to provide appropriate intervention earlier in the treatment process. The findings of a study examining the effects of trauma-integrated services suggest that women who receive these mental health services may engage in treatment longer (Amaro et al. 2008).

Treatment environment and theoretical approach

Supportive therapy: The consensus panel's clinical experience has shown that women who abuse substances benefit more from supportive therapies than from other types of therapeutic approaches. Review of the literature indicates that positive treatment outcomes for women are associated with variables related to the characteristics of the therapist (e.g., warmth, empathy, the ability to stay connected during treatment crises, and the ability to manage countertransference during therapy; Beutler et al. 1994; Cramer 2002; Crits-Christoph et al. 1991). Women need a treatment environment that is supportive, safe, and nurturing (Cohen 2000; Grosenick and Hatmaker 2000; Finkelstein et al. 1997); the therapeutic relationship should be one of mutual respect, empathy, and compassion (Covington 2002*b*).

The type of confrontation used in traditional programs tends to be ineffective for women unless a trusting, therapeutic relationship has been developed (Drabble 1996). Early research on women in treatment demonstrated that women entered treatment with lower self-esteem than their male counterparts (Beckman 1994). Hence, the traditional practice during recovery of "breaking down" a person who abuses substances and rebuilding her as a person is considered unduly harsh and not conducive to effecting change among women who abuse substances (Covington 2008*a* rev., 1999*a*; Drabble 1996; Kasl 1992). Although designed

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

Collaborative approach: Leading practitioners in the field of substance abuse treatment for women suggest that effective therapeutic styles are best characterized as active, constructive, collaboratively and productively challenging, supportive, and optimistic (Covington and Surrey 1997; Finkelstein 1993, 1996; Miller and Rollnick 1991). Effective therapeutic styles focus on treatment goals that are important to the client. This may mean addressing issues of food, housing, or transportation first. Having her primary needs met builds a woman's trust and allows her to address her substance use. A collaborative, supportive approach builds on the client's strengths, encourages her to use her strengths, and increases her confidence in her ability to identify and resolve problems.

Effective therapeutic styles facilitate the client's awareness of the difference between the way her life is now and the way she wants it to be. The client and counselor agree to work together to identify the client's distortions in thinking—discrepancies between what is important to her and how her behavior and coping mechanisms prevent her from reaching her goals. Approaching treatment as a collaboration between equal partners—where the therapist is the expert on what has helped other people and the client is the expert on what will work for herself—may reduce the client's resistance to change.

Type of treatment services

Same-sex versus mix-gender groups: While literature (Grella 1999; Gutierres and Todd 1997; Niv and Hser 2007; Roberts and Nishimoto 1996; Zilberman et al. 2003) generally supports same-sex groups as being more beneficial than mix-gender groups for women, most research surrounding this issue is either too small to generalize, fails to control for other factors that may influence results, or falls short in matching and evaluating same-sex and mix-gender groups using comparable services and program lengths. Inconsistent results are evident when comparing retention and outcome rates between both groups (Kaskutas et al. 2005). Historically, research has not controlled for the confounding variable that female-only groups provide more gender-responsive services than mix-gender groups. These enhanced services may be more responsible for retention and outcome than the gender constellation of treatment. In one study comparing women in a female-only program to a mix-gender group, the author concluded that just placing women in a same-sex group without women-specific treatment services is not effective in improving retention or outcome (Bride 2001).

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

Note to Clinicians

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

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

Service delivery: Women who have access to various services in one location appear to have higher retention rates (McMurtrie et al. 1999; Volpicelli et al. 2000). In addition, studies support that women who are involved in or initially receive greater intensive care, specifically residential treatment, are more likely to remain in treatment and in continuing care (Coughey et al. 1998; Strantz and Welch 1995). Retention is also heightened when treatment services also include individual counseling for women (Nelson-Zlupko et al. 1996).

Onsite child care and child services: In two randomized studies (Hughes et al. 1995; Stevens and Patton 1998) comparing women in residential programs whose children stayed with them versus women whose children did not stay with them, women whose children stayed with them had a longer length of stay (retention). Other less rigorous studies provide similar results (Ashley et al. 2004; Metsch et al. 2001; Nelson-Zlupko et al. 1996; Wobie et al. 1997). For more information on children in residential treatment programs, see chapter 5, "Treatment Engagement, Placement, and Planning."

Therapeutic alliance and counselor characteristics

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

Staff gender: Research on the impact of gender differences in client–counselor relationships is limited across mental health professions and is nearly non-existent in the substance abuse field. Although women show greater preference for female staff in addiction treatment, further research is needed in examining the role of gender in treatment retention and outcome among women in individual versus group counseling, same-sex versus mix-gender groups and treatment programs, and women at different levels of substance abuse treatment. In a study that examined how clients in inpatient substance abuse treatment would view their ideal male and female counselor, gender was not considered an important variable even

Implications for the Male Counselor

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

Improving Transitions and Retention Rates for Women

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

though the majority of clients preferred a female therapist (Jonker et al. 2000). Prior research on therapist preference in counseling highlighted that nearly 95 percent of women who expressed a preference specified a female counselor (Stamler et al. 1991). Grosenick and Hatmaker (2000) reported that 82 percent of the women and treatment staff in a residential program treating pregnant women and women with children believed it was important to have female staff, while 38 percent of the clients and 46 percent of the staff sample asserted that male staff were important. For those who endorsed the importance of male staff, they indicated that men serve as male role models for children and provide a male perspective on various clinical issues, such as relationships.

In a study that examined the influence of both client–counselor race and gender composition in treatment retention among African-American clients in intensive outpatient groups (Sterling et al. 1998), no significant gender differences were found. Nonetheless, several trends were evident. Female clients treated by female counselors stayed in treatment 5 days longer than mix-matched gender groups (mix-matched refers to clients being matched to counselors of the opposite sex), and women in gender-matched groups at discharge were more likely to continue outpatient care. The authors suggested that different results may have transpired if they had examined the role of gender and race in client–counselor relationships in individual substance abuse counseling versus group therapy. Research focused specifically on client–counselor race and gender composition in women's treatment is lacking.

Client's confidence in the process

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

Theoretical Approaches for Women

In a meta-analysis of studies on treatment approaches, Wampold (2001) attributed more than half of the effect of therapies to therapeutic alliance—a key element of all the theoretical approaches. Some approaches have significant clinical and empirical support in substance abuse treatment research literature (including motivational interviewing, cognitive–behavioral therapies, and some psychodynamic

approaches), however, research highlighting the role of gender differences is in its infancy, and limited research is available that delineates gender-specific factors that contribute to the effectiveness of these therapies. Data available at the time of publication is referenced throughout this TIP. For general information on counseling theories, refer to TIP 34 *Brief Interventions and Brief Therapies for Substance Abuse* (CSAT 1999*a*); TIP 35 *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999*b*); and TIP 47 *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment* (provides an overview of counseling theories; CSAT 2006*c*).

Women's Treatment Issues and Needs

Relationships and the Need for Connection

Relationships are central in women's lives—as part of their identities, as sources of self-esteem, as the context for decisionmaking and choices, and as support for day-to-day living and growth (Covington and Surrey 1997; Finkelstein 1993, 1996; Miller 1984). Connections are relationships that are healthy and supportive—mutual, empowering, and emotional resources. "Disconnections" involve relationships that are not mutual and empowering: one member is dominant, there is imbalance in the give and take, or a disparity exists in emotional supportiveness. Disconnections range from feeling "unheard" or "unknown" to extreme forms of disconnection, such as sexual abuse and violence. Disconnections create major difficulties for most women, such as lowered self-esteem, feelings of powerlessness, and lack of assertiveness. The experience of relationships as connections and disconnections is a central issue in personality development, with repeated severe disconnections potentially having serious psychological and behavioral consequences.

The Influence of Family

Treatment providers should be sensitive to the relational history women bring into treatment, both positive and negative. For instance, the extended family often functions as a safety net that provides women with child care, financial support, and emotional and spiritual guidance (Balcazar and Qian 2000). However, few studies have examined the role of the extended family in the development of substance abuse and recovery. While research on the extended family tends to define its role as primarily protective, drinking and drug use in the family can contribute to the development of abuse. Many women who abuse substances were raised in families where there was chemical abuse, sexual abuse, violence, and other relational disconnections. These family relationships form a basic model for the relationships women later develop with others.

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

To assess the impact of a client's family relationships, treatment providers should explore the role of the extended family in her life and try to determine how her substance abuse has affected her relationships with family members. Counselors should also help a client to explore her current relationships outside her family in the light of her substance use. Counselors may need to work with some clients to help them understand the negative effects these relationships can have.

In addition, skills related to improving the quality of relationships—such as communication, stress management, assertiveness, problemsolving, and parenting—can be an important part of treatment. To help clients learn these skills,

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

If maintaining or reconnecting with extended family members is not an option, plans should be made to find alternatives in developing a support system or a "family of choice." However, the grief associated with the loss of the original family needs to be addressed. Treatment programs can help women connect with natural supports in the community—friends, work colleagues, and significant others (Knight and Simpson 1996). Developing or maintaining

Advice to Clinicians: Relational Model Approach

Beginning in the 1970s, a number of theorists started to examine the importance of gender differences in psychological development. Jean Baker Miller's Toward a New Psychology of Women (1976) offered a new perspective on the psychology of women that challenged the basic assumptions of traditional theories. Carol Gilligan, a developmental psychologist, gathered empirical data on fundamental gender differences in the psychological and moral development of women and men (Gilligan 1982).

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

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

The relational-cultural theory affirms the power of connection and the pain of disconnection for women, with repeated disconnections having adverse consequences for mental health (Covington and Surrey 1997; Jordon and Hartling 2002). As a result, the approach requires a paradigm shift that has led to a reframing of key concepts in psychological development, theory, and practice. For example, instead of using the "self" as the sole focus, the model focuses on relational development.

According to Miller, "Women's sense of self becomes very much organized around being able to make and then to maintain affiliations and relationships" (Miller 1984, p. 83). More than men, women find an activity more satisfying and more pleasurable when others are involved. Therefore, for women, relationships directly affect their feelings of empowerment, self-worth, and self-esteem.

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

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

Partner Relationships

Many women drink and use substances to maintain relationships and cope with the pain and trauma of lost relationships. Some women feel they are expected to maintain relationships at all costs, even if those relationships are undermining, abusive, or otherwise detrimental. Women may stay in harmful relationships because of economic or social dependence. Treatment providers sometimes unknowingly reinforce this expectation by focusing on the importance of relationships to the exclusion of helping their clients increase their feelings of autonomy, healthy solitude, and individuality—also important needs for women.

Once a woman's significant relationships have been examined relative to her substance use, the counselor and client can work together on a plan for reconnecting with significant others during recovery (if possible). Yet, engaging a partner in a woman's treatment can be challenging, especially in balancing issues of the woman's and her partner's needs, safety concerns, and lack of funding for partner and family services. Few models within women's treatment programs exist that include partners and other family members, and even fewer address lesbian partners. Price and Simmel (2002) provide an overview of the issues surrounding a partner's influence on a woman's addiction and recovery and examples of model programs. They recommend starting with a thorough assessment after a woman has identified her partner(s) and given permission to involve the partner in treatment.

As women become healthy through participating in treatment and developing appropriate relationships, and as other supports (e.g., financial, housing) are put in place, it is hoped they will choose to reevaluate relationships that are detrimental to their well-being and recovery. When women decide to end significant relationships, counselors should realize that ending these significant relationships is a real loss that must be mourned while new attachments are being created. However, some women often choose to continue to participate in, or may be unable to escape, destructive relationships.

Tolerating or accepting a client's relationships that the counselor finds objectionable is complicated because a woman's substance abuse frequently is maintained in connection with her partner (Amaro and Hardy-Fanta 1995), and maintaining this relationship can increase her risk of relapse. Thus, any relationship that enables a woman to continue to abuse substances or threatens her safety becomes a therapeutic issue between a counselor and a female client. The counselor should acknowledge a woman's feelings about that relationship, regardless of the counselor's opinion about what is best for the client. However, if a client is in danger of being victimized, the counselor should primarily be focused on ensuring her safety. Initially, staff should take immediate measures to increase physical safety in the treatment environment—in both outpatient and inpatient settings. In addition to validating her experience, it is important to help facilitate a safety plan that may necessitate additional referrals to domestic violence hotlines and shelters. To review a sample personalized safety plan for domestic violence, refer to Appendix D in TIP 25 *Substance Abuse Treatment and Domestic Violence* (CSAT 1997*b*).

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

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

Advice to Clinicians:
Considerations in Involving the Partner in Treatment

In deciding whether or not to involve a woman's partner in treatment, primary consideration should be given to her safety and to the partner's willingness to participate in treatment. The following important issues should also be assessed to determine participation and level of treatment involvement and to establish an appropriate treatment plan:

- **History of violence:** Has there been a history of violence in the relationship, including threats and other emotional, physical, and/or sexual abuse; protection orders; police reports; or citations for domestic violence or assaults? Is there a history of impulsivity with client or partner? Has there been a history of violence outside the relationship, in previous relationships, or with children? Is there a recognizable progression of violence in the relationship?
- **History of substance use in the relationship:** How influential has this partner been regarding the client's continued drug and alcohol use? Does the partner see the woman's alcohol and/or drug use as a problem needing treatment? Has the history of the relationship been centered upon using or providing drugs and alcohol? How often are alcohol and other drugs used when engaged in activities with each other or during sexual intimacy? Is the client or partner worried about having sex without being under the influence of substances? Has the client left prior treatment experiences prematurely due to this relationship? Is the client worried that her partner is going to leave either as a result of her use or of her treatment? Does the client acknowledge that her use has impacted the relationship? Is she able to describe how her substance use has affected the relationship?
- **Partner's history of substance use:** What is the partner's attitude toward alcohol and drug use? Does he/she use as well? Is he/she in recovery? Has the partner been arrested, charged, or convicted of alcohol or drug related offenses? Does the client minimize the influence of her partner's current drug and alcohol use?
- **Accessibility:** Does the partner have the financial resources and transportation to attend treatment? Are there potential barriers that limit physical attendance, such as distance from program, transportation, work schedule, financial resources, childcare responsibilities?
- **History of mental illness:** Are there any known mental health issues with the partner or client that have or will impact the relationship?
- **Relationship support of the partner:** Has the partner been emotionally supportive throughout the history of the relationship? Currently, how emotionally supportive is the partner regarding the client's treatment and recovery? Does the partner play an essential role in childcare? Does the partner provide financial support? Has the partner ever threatened to leave, withdraw financial support, or threaten the custody of the children?
- **Commitment to relationship:** Is there a current commitment to maintaining the relationship?

Note to Clinicians

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

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

Sexuality

Healthy sexuality is integral to one's sense of self-worth. Sexuality represents the integration of biological, emotional, social, and spiritual aspects of who one is and how one relates to others. If healthy sexuality is defined as the integration of all these aspects of the self, it is apparent how substance abuse can have an impact on every area of a woman's sexuality. In addition, sexuality is one of the primary areas that women say change the most between substance abuse or dependence and recovery and is a major trigger for relapse (Covington 2008*a*, 1999*a*, 2007).

Women and men are socialized into different gender roles. For example, many men are taught to seem knowledgeable about sex and be comfortable with their bodies. In contrast, women struggle more with body image and are socialized to be less assertive sexually or risk being labeled as promiscuous. This polarization of sex roles is mirrored in society's belief about male and female substance use. Women who use substances are perceived as being more eager for sex and more vulnerable to seduction (George et al. 1988). This is reflected in the stronger stigma against women with substance use disorders, which is often expressed in sexual terms and labels women as promiscuous or sexually loose. Sexual terms are rarely used to describe men with substance use disorders.

Recovery and healing goes beyond abstinence from alcohol or drugs to developing relationships with others. Many women will need to explore the connections between substance abuse and sexuality, body image, sexual identity, sexual abuse, and the fear of sex when they are alcohol and drug free. Therefore, the consensus panel believes that discussion of women's sexual issues is an important part of substance abuse treatment. The following are some of the sexual concerns that women report during early recovery:

- *Sexual identity*. Counselors may need to help a woman determine her sexual identity as a heterosexual, lesbian, or bisexual person. Substance abuse during adolescence can interrupt the healthy development of sexual identity. Circumstances such as prostitution or incarceration may lead women to participate in sexual activity with other women. Some women use drugs to suppress their sexual feelings toward other women. Others use drugs to act on their erotic attachment to other women and may feel confused about their sexual identity when in recovery. Once the substance of abuse has been removed from a woman's life, the counselor can help her discover whether her identity is heterosexual, lesbian, or bisexual (Covington 1997). For review of sexual identity stages of development and its relationship to substance abuse, see *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals* (CSAT 2001*b*, pp. 61–67).
- *Fear of sex while abstinent*. Many women enter treatment with little or no experience of sexual relationships without being under the influence of substances. For women with a history of sexual trauma, using alcohol and drugs to manage emotions while having sex may have served as an important coping mechanism. Subsequently, women may become fearful of having sex without the assistance of substances (Covington 2000,

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

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

Depending on your goal, you can have the client focus only on the men or women who have been most influential in their lives. Generally, the exercise provides more clarity for the client if you focus on only one gender at a time. Yet, your selection depends on your treatment goal, the client's current struggles, and previous relationship history. If the woman is having a difficult time connecting with other women in treatment, it may be helpful to start with a history of her female relationships. Even though there are other ingredients that influence how a woman relates to and views other women (namely gender socialization), a sociogram that begins with the history of female relationships may enhance awareness of the issues that impede her ability to relate to other women. At other times, it may be more fruitful to focus on the history of male relationships with women due to clinical issues that involve men. Here are directions and a sample of a sociogram on female relationships:

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

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

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

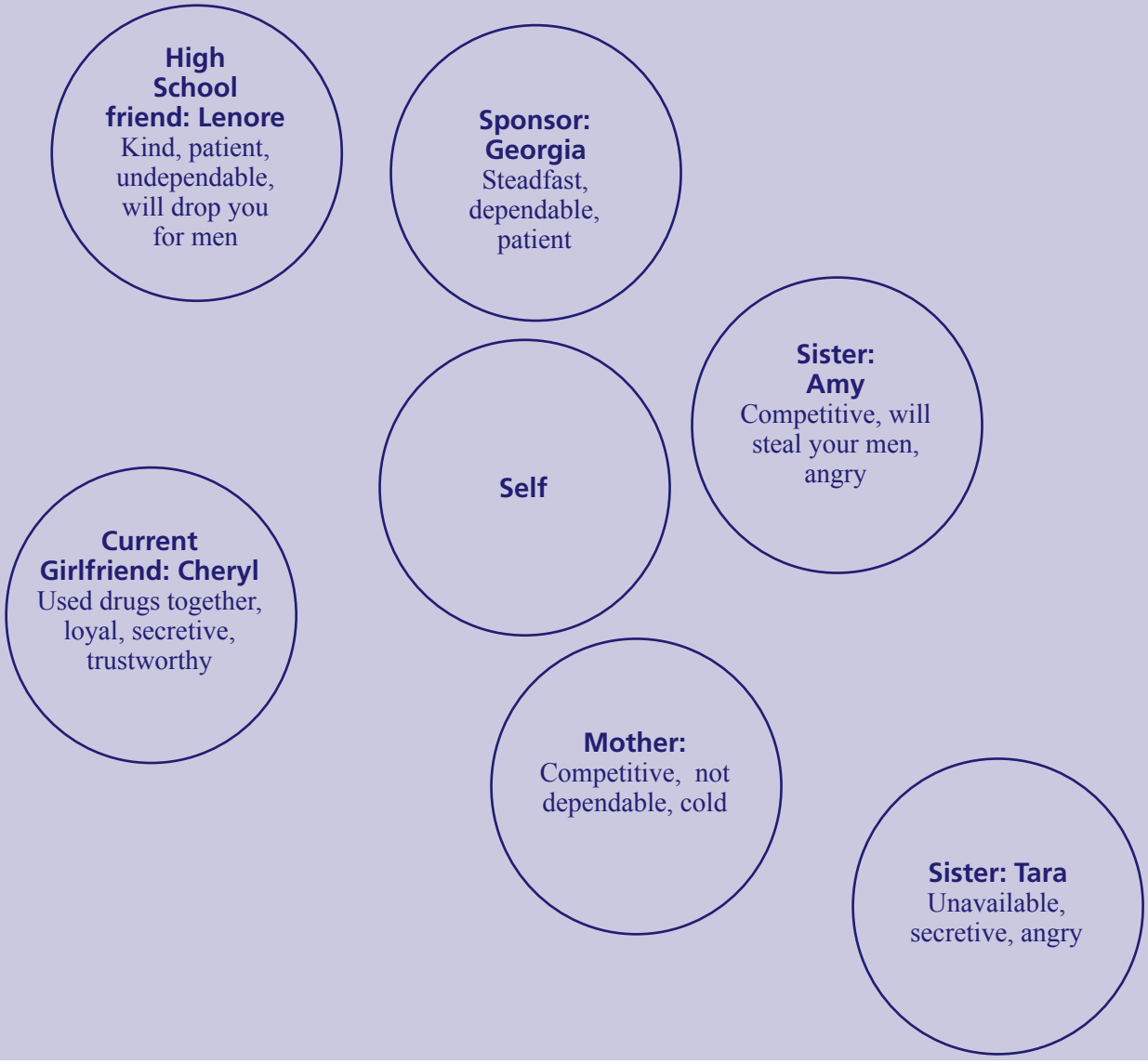
Upon completion, have the client present her sociogram. This exercise works quite well in a women's group and in individual counseling. In group, it promotes a dynamic discussion on how women learn to relate to each other, and it creates an opportunity to understand how each client's history of female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

Clinical Activity: Exploring the History and Influence of Relationships: Sociogram (continued)

Are there any themes or recurrent patterns in this sociogram?

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

Sample Sociogram Exercise: "What have I learned from each relationship about other women?"



1997). Trauma survivors may view sex as taboo or hurtful and their sexual responses as bad. In addition, sexual relationships sometimes can trigger painful memories of past abuse that can create difficulties for women, particularly in early recovery (Covington 1997; Finkelstein 1996).

- *Sexual dysfunctions*. Alcohol and drugs interfere with sexual sensitivity and enjoyment in many ways. They disrupt the delicate balance of a woman's hormonal system, interfering with her body's emotional, reproductive, and physiological functions (Greenfield and O'Leary 2002). Women with substance use disorders have the same kinds of sexual dysfunctions as those without the disorder (lack of orgasm, lack of lubrication, lack of sexual interest, etc.), but they have more problems more often (Covington 2000).
- *Sexual and interpersonal violence*. Sexuality often is associated with violence and abuse for female clients with histories of trauma. Consequently, they may be fearful, angry, and distrustful, and have difficulty functioning sexually. Given the association between substance abuse and sexual abuse (Ullman et al. 2005), women who have been abused may use alcohol or drugs to numb the emotional pain of the abusive experience. This can create a spiraling relationship where many women use substances to alleviate the sexual difficulties they are experiencing. But the alcohol or drugs only exacerbate the problem. Women who are under the influence of drugs are at greater risk for sexual and physical aggression (Blume 1991; Testa et al. 2003), and this remains true with pregnant women who have substance use disorders (Velez et al. 2006).
- *Sexually transmitted diseases (STDs)*. The use of alcohol and drugs increases the likelihood of contracting STDs, including HIV/AIDS. There are three primary reasons for this increased risk. When drunk or high, many women neglect to protect themselves against STDs or to make sure they do not use contaminated needles (Evans et al. 2003; Pugatch et al. 2000). Often women with substance use disorders find themselves in relationships with men who are also chemically dependent, thereby increasing the risk that their partner may have STDs or are HIV positive. In addition, rates of other infectious diseases among women with substance use disorders tend to be higher than among other female populations (CSAT 1993*c*; Grella et al. 1995). Notably, preliminary findings suggest that women who inject illicit drugs and have sex with other women exhibit increased HIV infection and risk behaviors in comparison to other people who use injection drugs (Young et al. 2005).

In addition to research pertaining to prevalence, counselors need to address clinical issues associated with infectious diseases. Specifically, shame and stigma are highly associated with sexually transmitted diseases and HIV infection (Fortenberry et al. 2002), and, as a result, women who are addicted and infected with a sexually transmitted disease are likely to perceive and experience a more profound sense of shame and higher levels of stigma—potentially serving as a barrier to engaging in help-seeking behavior.

Pregnancy

Pregnancy creates stress for many women. Literature suggests that this stress can come from the woman's physical discomfort; her anxiety about the health of her fetus and how she will care for her baby; or her shame from the social stigma of using drugs, alcohol, or tobacco while she is pregnant (Daley et al. 1998). Providers can create an atmosphere that supports talking freely about pregnancy and recognize that ambivalence toward pregnancy is a normal reaction. Counselors should make a careful assessment of the woman's existing parenting and other family responsibilities and of the social services and economic resources the mother needs.

Some women experience feelings of ambivalence about their pregnancy that become apparent during treatment. Educational programs, particularly for young women, that review the effects of alcohol, drug, and tobacco use on pregnant women and their fetuses may

provide motivation to enter treatment, but this information will probably also generate concern over the status of their fetus. Counselors should be supportive of the client as she processes this emotionally difficult information. Counselors must understand a woman's guilt, shame, and unspoken feelings about the effects of substance use on fetal health and development. Counselors can advocate for fetal well-being but must also give the mother information that is nonjudgmental. It is important for counselors to stress that "it is never too late to stop," and that whenever pregnant women reduce or stop drug and alcohol use, benefits are obtained!

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

After detoxification and stabilization, counselors should offer the important message that abstinence, staying in substance abuse treatment, and prenatal care can reduce the impact of substance use on the fetus (Bolnick and Rayburn 2003). Research indicates that a positive environment is as enriching to a child's early growth and development as prenatal exposure to substances is detrimental (Frank et al. 2001; Hurt et al. 2001). After the child is born, a mother can work to create a positive environment for her child's healthy development. This approach emphasizes the recovering woman's control and self-efficacy; it is another element of empowerment for recovering women (Covington 2002*a*).

Parenting

A woman's relationship with her children and her identity as a mother play a vital role in her sense of self. These relationships are important in recovery from substance use disorders. The consensus panel believes that substance abuse treatment programs should offer treatment that addresses the critical component of parenting connections to children, as well as a full range of children's physical and mental health care, along with other services, whether within a treatment program itself, or by referral to a collaborating agency. Refer to chapter 5 for more specific information on programming across each level of care for women who are pregnant and/or have children.

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

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

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

Parenting programs

Research findings are inconsistent in demonstrating the effectiveness of behavioral parenting programs for improving the parent–child relationship and children's psychological adjustment among mothers who have substance use disorders (for review, see Suchman et al. 2004; Suchman et al. 2007; Velez et al. 2004). More research is needed to evaluate the most effective parenting approaches and to address research methodological issues surrounding parenting program evaluations. In general, literature appears to support combining behavioral training with attachment-based parenting interventions (relational model).

A strengths-based relational approach to parenting assumes maternal assets already exist that can be identified and built on, and that the emotional quality of the parent–child relationship is equally important in improving the parent–child relationship and psychological adjustment of the child. In essence, parenting is a relationship—not solely a set of skills. Some topics for parenting skills and relationship building include:

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

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

Children affected by maternal alcohol and drug dependence have increased vulnerability for physical, social-emotional, and academic problems (Conners et al. 2004; VanDeMark et al. 2005). Moreover, analysis from SAMHSA's Women, Co-Occurring Disorders and Violence Study (WCDVS) suggests that children are also at an increased risk for physical child abuse when the mother has a current history of mental health symptoms, alcohol and drug use severity, and trauma (Rinehart et al. 2005). Thus, children need more than just adequate child care.

The consensus panel recommends that an onsite child specialist or one available by referral should be a standard element of programs that include children. Assessment and screening for developmental and learning delays and social problems is necessary, as are play and expressive therapies that help children acknowledge and express feelings about their parents' problems. Children should be provided with information regarding their mother's substance use disorder in an age-appropriate

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

While a woman is learning to parent, her children need assistance to overcome the effects of her substance abuse. It is likely their mother has been emotionally and physically unavailable at times. Counselors can help children realize that their mother's behavior was unintentional and, as she regains control of her life, she will likely become more available. In addition, Alateen; psychoeducational curricula, such as the National Association for Children of Alcoholics "Celebrating Families™;" and onsite individual and group therapy can provide further support to children.

Parenting issues for women with trauma histories

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

- Many women feel shame, guilt, and self-blame, which can interfere with their emotional availability to their children. This includes a mother's self-criticism or depression when evaluating current parenting as well as her belief that she deserves blame for inadequate parenting, or feeling that her children's behavior is an attack because they had inadequate parenting.
- Interaction with a child can trigger a mother's traumatic past. This includes experiencing a child's misbehavior as a traumatic trigger, children's distress or need for bonding reminding a mother of her own vulnerabilities, and having posttraumatic stress disorder (PTSD) symptoms triggered by normal developmental events such as breastfeeding, bathing a child, and providing sexual education to a child. Likewise, a mother may experience heightened anxiety and vigilance when one of her children reaches the same age that her own prior sexual abuse or trauma began or occurred. For example, if a client witnessed her younger brother getting shot when she was 12, she may encounter more traumatic stress symptoms as her oldest child reaches the same age as her brother.
- A mother may internalize and reenact the role of both victim and perpetrator in response to trauma. This may cause her to worry that her children will be mistreated and lead to either overprotectiveness or helplessness, a reluctance to set limits out of fear of identifying with a perpetrator.
- Female clients will need to come to terms with having been inadequately nurturing parents at times and with the complexities of providing a better relationship with their children (Melnick and Bassuk 2000).

Trauma-informed parent training assists mothers in identifying their triggers, learning appropriate boundaries and discipline, and learning nurturing behaviors so they can care for their children in healthy ways. As the mother becomes more stable, she will need to be prepared for the possibility that her children will feel safer in acting out their previous distress. Programs can prepare women in early recovery for this predictable event with information, coaching for effective parenting, and reframing the children's behavior as a signal that they feel safer and can afford to express themselves.

Children who are not in a mother's care

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

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

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

Children with special needs

Some mothers with substance use disorders have children with special needs, possibly as a result of alcohol or drug use during pregnancy, inadequate prenatal care, poor nutrition during pregnancy, or other factors. In addition to coping with the personal guilt, mothers will find that these children demand extra care and attention and create additional stresses during recovery. Careful assessment of these children by trained professionals is essential. An educational and/or treatment plan should result from an assessment that is integrated with the mother's treatment plan. Because so many of the children who are included in treatment with their mothers have emotional or developmental problems, there is a real need for child specialists on staff (Conners et al. 2004; CSAT 2000*b*). A linkage to programs for children with special needs and children with disabilities would be an asset in providing the services these children need.

History of Trauma

Trauma can result from numerous experiences, including emotional, physical, and sexual abuse, as well as assault, war, natural disasters, terrorism, and interpersonal violence that occurs between family members or with intimate partners. Women who experience or witness violence, particularly actions that threaten their lives and safety, can become traumatized by these events (Herman 1997). The *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision* (DSM-IV-TR) defines trauma as "involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate" (American Psychiatric Association [APA] 2000*a*, p. 463).

Women respond to and are affected by trauma in a variety of ways. Based on their histories, circumstances, and other factors, some women experience traumatic stress symptoms that dissipate over time, while other women are resilient to the effects of trauma and recover from it quickly (Foa and Rothbaum 1998). Some women develop psychological disorders including PTSD and other anxiety and mood disorders, and other women may use alcohol, tobacco, and drugs to cope with the trauma and its symptoms. Still others may replicate their trauma by engaging in problematic parent–child interactions, including abuse and neglect (McMahon and Luthar 1998). A family history of anxiety, early traumatic violence, and repeated exposure to trauma can predispose an individual to develop severe problems. The Adverse Childhood Experiences Study (Felitti et al. 1998) reflected a strong association between health risk behavior and disease for both adult men

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

The relationship between trauma and substance abuse

Substance abuse and victimization appear to be highly correlated; drug abuse increases the risk of violent assault, and victimization appears to increase the risk of substance abuse (El-Bassel et al. 2005; Kendler et al. 2000; Kilpatrick et al. 1997). Nevertheless, the connection between substance use and abuse and interpersonal violence often is complex, especially for women. Men who abuse substances are at high risk of committing violence against women and children. Women who use substances are more at risk for being abused because of relationships with others who abuse substances, impaired judgment while using alcohol or drugs, and being in risky and violence-prone situations (Testa et al. 2003). Survivors of abuse may become dependent on alcohol and drugs to manage trauma symptoms and reduce tension and stress from living in violent situations. Thus begins a cycle of "victimization, chemical use, retardation of emotional development, limited stress resolution, more chemical use, and heightened vulnerability to further victimization" (Dayton 2000; Steele 2000, p. 72).

A history of trauma is common in the lives of women with substance use disorders. Female survivors of sexual trauma were found, in one study, to be dependent on more substances, to have had more hospital stays and emergency department visits, and to be less able to care for their children than women who had not been sexually abused (Young and Boyd 2000). Girls who suffer physical and sexual abuse by dating partners are more likely to engage in risky behaviors such as smoking, binge drinking, and cocaine use (Silverman et al. 2001). In another study, adverse childhood circumstances predicted binge drinking among adult women (Timko 2008).

Alcohol and drug use by trauma survivors can be adaptive at first. Some victims use substances to numb psychological effects of the trauma. Some substances help survivors dissociate the trauma from their consciousness (Herman 1997). Women who have histories of violence and trauma have a higher propensity for substance use disorders and are more likely to encounter a difficult recovery from substance use disorders. Their treatment is typically complicated because of the interrelationship between trauma and substance use, the role that substances play in managing traumatic stress symptoms, and sequelae from the experience of trauma such as depression and other psychological disorders. To obtain more specific information on the impact of trauma, traumatic stress disorders, symptoms of PTSD and associated symptoms, and treatment approaches, refer to TIP 42 *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005*e*) and the planned TIP *Substance Abuse and Trauma* (CSAT in development *h*).

Interpersonal violence

Violence dramatically affects the physical and emotional health of victims and witnesses. The United Nations defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life" (United Nations General Assembly 1993, p. 2). The National Violence Against Women Survey (Tjaden and Thoennes 1998; 2000; 2006), conducted in 1996, estimated that in the year before the survey, almost 2 million women were physically assaulted and more than 300,000 women experienced a completed or attempted rape. Estimates of lifetime incidence increased to more than 50 million women who were physically assaulted and almost 20 million who experienced rape or attempted rape. Moreover, sociologists have commented that this level of violence has created a culture of fear for many women, observing that women feel they need to be alert and aware of their surroundings to protect themselves against assault and rape (Gordon and Riger 1989).

Women are more likely to become victims of intimate partner abuse (Catalano 2007), and men and women become victims of interpersonal violence under different circumstances. Women often experience violence in the privacy of their home (Catalano 2007; Covington 2002*a*; Tjaden and Thoennes 2006). Both boys and girls are at risk for physical and sexual abuse by parents and people they know, but this risk changes over the course of life. As girls move into adolescence and adulthood, they continue to be at risk for interpersonal violence. Often their abuser is someone with whom they have a relationship. For example, about one in five high school girls reportedly has suffered sexual or physical abuse from a boyfriend (Ackard and Neumark-Sztainer 2003; Silverman et al. 2001, 2004). For an overview of violence and women, see Figure 7-1.

Violence and abuse also occur in lesbian relationships. While research is limited, studies reviewed by Renzetti (1993) have indicated that lesbians experience partner violence at about the same rate as heterosexual women. As is the case with violence in heterosexual relationships, alcohol consumption often is part of the battering (Schilit et al. 1990). In comparing the prevalence of domestic violence between homosexual males and females, the National Coalition of Anti-Violence Programs (2007) reports there are no overall differences.

Childhood sexual and physical abuse

A history of childhood sexual or physical abuse (or both) is a significant risk factor for the development of a substance use disorder (Evans and Sullivan 1995). Two models help explain this—the distress coping model and the emotion regulation model. It is likely that substances not only serve as means of coping with negative emotions generated by childhood abuse, but

Figure 7-1
Violence and Women

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

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

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

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

Clinical studies have documented that up to 75 percent of women in substance abuse treatment have a history of physical and/or sexual abuse (Ouimette et al. 2000; Teusch 1997). Earlier studies have shown that women who abuse substances are estimated to have a 30- to 59-percent rate of current PTSD (Najavits et al. 1998), which is higher than the rate in men who abuse substances (CSAT 2005*a*). A history of sexual and/or physical abuse puts women at risk for psychiatric hospitalization (Carmen 1995), depression (Herman 1997; Ross-Durow and Boyd 2000), eating disorders (Curtis et al. 2005; Janes 1994; Miller 1994; Smolak and Murnen 2001), and self-inflicted injury (Dallam 1997; Haswell and Graham 1996; Miller and Guidry 2001). See also TIP 36 *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT 2000*b*).

Co-Occurring Disorders

When working with women with co-occurring mental and substance use disorders, substance abuse treatment counselors need to apply the tools of the mental health professional, especially in knowing when and where to refer clients with co-occurring disorders. Substance abuse treatment providers do not necessarily have to be trained as mental health professionals, but making appropriate referrals and coordinating the services needed by these clients requires a solid grasp of the differences in treatments, role of medications, and available resources. The following section provides an overview of co-occurring issues and highlights three disorders that are prevalent in substance abuse treatment among women. For more in-depth coverage of treatment for those with co-occurring substance use and mental disorders, review TIP 42 *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005*e*).

An overview of issues

Both the substance abuse and mental health care fields understand that clients can enter treatment with issues they perceive as interwoven, whether or not the services themselves are. To address the dilemmas facing the people they serve, mental health, substance abuse, and trauma services are opening a dialog with one another, paving the way toward providing an appropriate, integrated system of care for each client in every system.

An integrated care framework provides assessment and treatment wherever the woman enters the treatment system, ensures necessary consultation for her issues when a given individual or program does not have the necessary expertise, and encourages all counselors and programs to develop competence in addressing co-occurring disorders. When women are assessed at a facility that does not have all the services they need, staff members at that facility are responsible for ensuring that the women are assessed at other appropriate facilities. Too often, services may over- or under-treat one of the disorders (Miller 1994*a*). Staff members also are responsible for following up with the cooperating facility to ensure that clients receive proper care.

The need for ongoing evaluation of co-occurring disorders is critical because both substance abuse and substance withdrawal can mimic or mask co-occurring psychiatric disorders. The client's internal turmoil can result in overwhelming affect and chaotic behavior that creates heavy demands for providers. Women with co-occurring substance use and mental disorders are likely to have PTSD, other anxiety disorders, depression, or eating disorders (particularly bulimia). While women are also more willing to identify social and psychiatric problems, they appear to have more difficulty

in acknowledging problems with substance use (Mangrum et al. 2006). Treatment services that provide an integrated system of care can naturally assist women in exploring the interaction and impact of substances and mental health without supporting or reinforcing the polarization of each disorder that can arise when one disorder is easier to acknowledge by the client.

Co-occurring mental and substance use disorders often result in poor psychosocial functioning, health problems, medication noncompliance, relapse, hospitalizations, homelessness, and suicidal behavior (Reed and Mowbray 1999). Co-occurring disorders are associated with poorer treatment outcomes for women with substance use disorders and contribute to high rates of treatment dropout (Bernstein 2000). Among women in the child welfare system, the prevalence of co-occurring disorders is high and the need for services is paramount. More often than not, mothers' co-occurring disorders interfere with the likelihood of family reunification—especially if there are numerous needs, such as vocational, housing, and mental health services (Choi and Ryan 2007). Thus, appropriate referrals and case management are needed to retain these clients in substance abuse treatment and to afford the best possible outcome for women and their children.

Pregnant women and co-occurring mental illness

Pregnancy can aggravate the symptoms of co-occurring mental illness. This can be a result of the hormonal changes and stresses that occur during pregnancy, some medications given during pregnancy or delivery, the stresses of labor and delivery, the challenges and hormonal changes with lactation, and adjusting to and bonding with a newborn (Grella 1997). Women with co-occurring disorders sometimes avoid early prenatal care, have difficulty complying with healthcare providers' instructions, and are unable to plan for their babies or care for them when they arrive. According to the literature, women with anxiety disorders or personality disorders have a greater risk of postpartum depression (Grella 1997), and mood disorders affect treatment outcome among pregnant women who are drug dependent (Fitzsimons et al. 2007). More outcome research is needed to evaluate the role of co-occurring disorders among pregnant women and the impact of treatment for co-occurring disorders on prenatal and postnatal care.

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

Advice to Clinicians: Women With Co-Occurring Disorders

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

Source: DiNitto and Crisp 2002.

Postpartum Depression: An Under-Diagnosed Disorder

According to the DSM-IV-TR (APA 2000*a*), postpartum depression begins within 4 weeks after delivery. Episodes occurring after this period are considered "ordinary" depression. Risk factors for postpartum depression include a history of depression, psychological distress or psychiatric diagnosis before or during pregnancy, or a family history of psychiatric disorders (Nielsen Forman et al. 2000; Steiner 2002; Webster et al. 2000). Prospects for recovery from postpartum depression are good with supportive psychological counseling accompanied as needed by pharmacological therapy (Chabrol et al. 2002; Cohen et al. 2001; O'Hara et al. 2000). Antidepressants, anxiolytic medications, and even electroconvulsive therapy have all been successful in treating postpartum depression (Griffiths et al. 1989; Oates 1989; Varan et al. 1985). (Note that some medications pass into breast milk and can cause infant sedation.) Patients with postpartum depression need to be monitored for thoughts of suicide, infanticide, and progression of psychosis in addition to their response to treatment.

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

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

Postpartum blues is temporary depression occurring most commonly within 3–10 days after delivery and may be caused by progesterone withdrawal (Harris et al. 1994), a woman's emotional letdown that follows the excitement and fears of pregnancy and delivery, the discomforts of the period immediately after giving birth, fatigue from loss of sleep during labor and while hospitalized, energy expenditure at labor, anxieties about her ability to care for her child at home, and fears that she may be unattractive to her partner. Anticipation and preventive reassurance throughout pregnancy can prevent postpartum blues from becoming a problem. Women with sleep deprivation should be assisted in getting proper rest. Symptoms include weepiness, insomnia, depression, anxiety, poor concentration, moodiness, and irritability. These symptoms tend to be mild and fleeting, and women usually recover completely with rest and reassurance. Followup care should ensure that the woman is making sufficient progress and not heading toward a relapse to substance abuse.

Postpartum depression is a more severe case of the postpartum blues that does not go away after a few days. Beyond the temporary weepiness, irritability, and emotional letdown that follows delivery, postpartum depression involves a longer-term experience of despair, discouragement, guilt, self-reproach, and withdrawal from social contact. In many ways, postpartum depression resembles the grief and mourning that follows bereavement. Women may also lose their appetite and thus also lose weight, experience insomnia and severe mood swings, and have trouble coping with simple daily tasks, including the care of their newborns.

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

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

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

Anxiety Disorders

Anxiety disorders encompass physiological sensations of nervousness and tension, psychological worry characterized often by apprehension and rumination, and behavioral patterns of avoidance linked to the perceived source of anxiety. Some anxiety disorders have stronger familial ties than others. Anxiety disorders can develop without an identified stressor or event or by exposure to acute or prolonged stress, (such as a traumatic event or a chronic condition such as living with poverty, in a dysfunctional family system, or as a result of migration and acculturation). PTSD, panic disorders, agoraphobia without panic, simple phobia, and generalized anxiety disorder are more common among women than among men (APA 2000*a*; Kessler et al. 1994; NIMH 2007). Among individuals with substance use disorders, traumatic stress reactions and PTSD are quite prevalent among women. As a result, this section will primarily focus on PTSD starting with a brief overview of treatment considerations for women with anxiety disorders. For more detailed information regarding anxiety disorders and trauma, refer to TIP 42 *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005*e*) and the planned TIP *Substance Abuse and Trauma* (CSAT in development *h*).

General treatment considerations for anxiety disorders

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

Note to Clinicians

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

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

Cognitive–behavioral therapies (CBT) are effective treatments for anxiety disorders (Hofmann and Smits 2008) including, but not limited to, stress inoculation and other anxiety management strategies, desensitization processes, and imaginal and in-vivo (live reenactments) exposure therapies. Nonetheless, other types of therapy that address the underlying stress-producing events may be required (Frank et al. 1998). Clinical experience indicates that women with anxiety disorders and substance use problems may benefit from alternative therapies as an adjunct to CBT, including acupuncture, exercise, and mindfulness meditation. One study indicated that socially phobic female outpatients being treated for alcohol dependence had better outcomes with CBT than with 12-Step facilitation therapy (Thevos et al. 2000).

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

PTSD

Although some type of trauma has been experienced by many women who use substances, not all women who have been traumatized will develop PTSD. An anxiety disorder, PTSD may involve other anxiety symptoms including panic attacks and avoidance (Brady et al. 2000). Refer to Appendix E for DSM-IV-TR criteria for PTSD. For those women who have PTSD, their symptoms will involve persistent re-experiencing of trauma-related events, avoidance of trauma-related material, and arousal (APA 2000a; Refer to Figure 7-2, p. 162, for PTSD symptom clusters). In addition, they will present other associated symptoms, such as depression and sleep disturbance. Subsequent to a heightened state of arousal, many women report significant sleep difficulties characterized by nightmares, trouble falling sleep, frequent awakenings or problems in staying asleep, and apprehension in going to sleep. Among women with a history of sexual assault and PTSD, sleep difficulties have been noted as a significant motive to drink (Nishith et al. 2001).

Along with the physiological and psychological symptoms that so often characterize PTSD, the experience of trauma can impact core assumptions and beliefs about self, others, and life (for review, see Janoff-Bulman 1992). One study (Hall 2000) demonstrated that the severity of the effects of trauma is evident in two core beliefs identified by survivors of childhood abuse who are in recovery: "I am nothing" (feeling inconsequential) and "I am bad or wrong." In addition to the abuse or trauma itself, experiences that lead to feeling inconsequential include being unprotected from danger, telling someone about the abuse but not being believed, being told lies to conceal the abuse, and being unprepared for life transitions. This can lead to shutting down emotions and social isolation (Boyd and Mackey 2000*a*; Hall 2000). The perpetrator may have put the blame on them ("you asked for it").

Treatment of PTSD

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

Note to Clinicians

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

Figure 7-2
PTSD Symptoms

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

Sources: APA 2000*a*; Cramer 2000; Melnick and Bassuk 2000; and Najavits 2002*b*.

sights, sounds, smells, or kinesthetic sensations and emotional states (van der Kolk 1996). Developing the ability to organize the traumatic events into coherent thoughts and narrative that can be expressed in some way can significantly lessen somatic symptoms (see Figure 7-3; van der Kolk 1996). Some treatment methods support the premise that the trauma must be made conscious, effectively experienced, and integrated into present life (Volkman 1993). Some treatments suggest that coping strategies are the effective path in addressing PTSD, while other approaches heavily rely on the premise that repeated and prolonged exposure to anxiety-evoking material will gradually reduce PTSD symptoms through the process of extinction/habituation (Foa et al. 2007). A review of psychological treatments for PTSD is beyond the scope of this TIP. For a review of treatments, refer to the article, *Psychosocial treatment of posttraumatic stress disorder: A practice-friendly review of outcome research* (Solomon and Johnson 2002), along with the TIPs highlighted in the introduction to the Anxiety Disorders section earlier in this chapter.

Women with substance use disorders and PTSD

Substance abuse and the effects of trauma interact in complex ways in an individual. A treatment provider cannot assume that one is a primary problem and the other secondary. Nor is it always beneficial to delay working on trauma symptoms until the client has been abstinent for a predetermined minimum amount of time. The counselor should focus on the client's current crisis and stabilizing her affect.

Substance abuse can prevent full recovery from PTSD, and continuing PTSD symptoms may perpetuate use of substances and the development of substance use disorders. Two studies report double the lifetime prevalence of PTSD in women than in men: 11.3 percent versus 6 percent and 10.4 percent versus 5 percent (Breslau et al. 1991; Kessler et al. 1995, respectively). These studies found that women were twice as likely as men to develop PTSD after exposure to a trauma, suggesting that women are particularly vulnerable to PTSD or that the particular type of trauma experienced by women is more likely to result in PTSD. In a study that sampled 558 cocaine-dependent outpatient clients on current rates and symptoms of PTSD, women were three times more likely to meet diagnostic criteria for PTSD (Najavits et al. 2003).

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

Figure 7-3
Helpful Skills for Trauma Victims

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

Source: Adapted from Harris and Fallot 2001*a*.

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

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

While women with PTSD appear to possess more psychological risk factors associated with relapse than men, another outcome study comparing men and women in an outpatient treatment setting highlighted that women are more likely to engage in treatment, thereby offsetting the higher risks for relapse (Gil-Rivas et al. 1996). Women with PTSD may benefit from relapse prevention therapy as an effective short-term treatment for substance use disorders and PTSD. In a study evaluating the efficacy of cognitive–behavioral relapse prevention therapy for substance use disorders (only), the "Seeking Safety" program (manual-based treatment for substance abuse and PTSD), versus "standard" community care, women who were engaged in either relapse prevention therapy or the "Seeking Safety" program showed sustained improvement in substance use and PTSD symptoms at 6- and 9-month followups in comparison to women in standard care (Hien et al. 2004).

Substance abuse treatment: Trauma-informed treatment approach

When providing treatment, clinicians need to be aware that most female clients are trauma survivors, even if they do not meet criteria for PTSD. During the past 20 years, the treatment community responded to this treatment need in varying ways. Several years ago, most providers first treated the substance use disorder then addressed trauma-related issues later. As knowledge in the field grew, collateral services were offered that treated substance abuse and trauma issues concurrently. A "trauma-informed" program has an awareness of the pervasiveness of traumatic events and translates that awareness into integrated services that support the coping capacity of clients. This capacity enables a woman to stay and participate in treatment, to engage in a positive therapeutic alliance, and to learn to cope with the aftermath or consequences of trauma. The text box below provides an example of a trauma-informed approach to treatment.

A trauma-informed approach adjusts services to meet the needs of women who have a history of trauma. In 6- and 12-month outcome studies evaluating program and person-level effects among women with co-occurring disorders and trauma (Morrissey et al. 2005; Morrissey et al. 2005*a*), programs that provided integrated services (mental health, substance abuse, and trauma) displayed increased positive effects on mental health and substance use outcomes. Programs can use Appendix F, Integration Self-Assessment for Providers, to determine the extent to which their agency integrates treatment for substance abuse, mental illness, and trauma.

To be trauma-informed means to know of past and current abuse in the life of a woman. But more importantly, it means to understand the roles that violence and victimization play in the lives of women seeking substance abuse and mental health services, to design integrated service systems that accommodate the vulnerabilities of a trauma survivor, and to deliver services that facilitate participation

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

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

Clinical considerations in trauma-informed services

A history of trauma should alert counselors to the potential for co-occurring mental disorders, such as PTSD, depression, anxiety disorder, or personality disorders that can impede treatment unless addressed early. Once the trauma has been identified either during the assessment process or in early treatment, the

The Women Embracing Life and Living (WELL) Project

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

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

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

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

Source: Markoff et al. 2005.

Note to Clinicians and Administrators

Preliminary data support that integrated trauma-focused interventions for women in substance abuse treatment programs appear to be safe, thus presenting no differences in adverse psychiatric and substance abuse symptoms or events in comparison to standard care (Killeen et al. 2008). So often, clinicians and administrators fear and hold the misperception that addressing trauma-related issues is counterproductive and produces deleterious effects on women in substance abuse treatment. While the selection of services and the planning on how these services are delivered is important in maintaining the integrity of care for the client, integrated trauma-focused interventions are not only a viable option but an essential component of treatment for women with substance use disorders.

counselor can begin to validate a woman's experience and acknowledge that she is neither unique in her experience nor alone. If women are not questioned directly, the abuse may go unrecognized and untreated. Many women who are dependent on alcohol or drugs experience difficulty in recovery and relapse if violence and abuse issues are not addressed in treatment. Women may need help understanding the serious long-term effects of violence, sexual abuse, and incest on their functioning and on the risk of relapse (Covington 2003; Finkelstein 1996; Najavits 2006).

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

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

- *Outreach*. Efforts to engage women in treatment include flexible scheduling, ready availability, identification of client interest in and need for treatment, and ongoing evaluation. Outreach includes informing the community of services offered and initiating contact with agencies that should refer women for assessment and counseling (Elliott et al. 2005).
- *Assessment and referral*. A counselor needs to understand the nature of a woman's exposure to trauma—the type of abuse, when it occurred, whether it was a one-time event or repeated over time, the relationship between the client and the perpetrator (family member, acquaintance, stranger), and what occurred if the woman previously disclosed the experience (Bernstein 2000). It requires treatment by a clinician who is trained in treating traumatic stress disorders. Women who score high on a posttraumatic stress assessment should be referred for treatment to address their PTSD concurrently with their substance abuse treatment. Counselors should be candid when they cannot provide the treatment the client needs and may need to make a referral.
- *Psychoeducation*. One of the counselor's major functions in treating a woman in recovery who has a trauma history is to acknowledge the connection between substance abuse and trauma. This acknowledgment validates a woman's experience and helps her feel that she is not alone and that her experience is not shameful. Sharing prevalence data can reduce her sense of isolation and shame (Finkelstein 1996).
- *Normalizing the symptoms*. In addition, it is important to educate and discuss the

Advice to Clinicians:
When Is a Woman Ready for Trauma Processing?

Many counselors and clients assume that "working on trauma" means telling the story of what happened. Although exposure therapy is a widely known treatment method (Foa and Rothbaum 1998), it is controversial in the substance abuse treatment field. Questions remain about whether it is a safe treatment to conduct with clients who are abusing substances or engaged in self-destructive behavior. A study on exposure therapy for people in substance abuse treatment showed that many clients could not tolerate the work, with 61.5 percent not completing the minimum dose of treatment. Those who engaged in the treatment did well in outcomes—including reducing substance use and employment problems—but more research is needed to determine client factors that would identify who would best benefit from this type of treatment (Brady et al. 2001).

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

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

typical symptoms associated with PTSD to help normalize the client's physiological and psychological experience. Similar to other anxiety disorders, clients are often overwhelmed by symptoms leading to the belief that they cannot manage them or that they are not going to survive them. Some relief arrives when a client knows that they are having a normal reaction to an abnormal event or set of circumstances.

- *Safety, support, and collaboration.* Trauma often creates profound disconnection in two areas: interpersonal relationships and internal feelings. Some women who experience traumas become isolated, feeling that the only safety is in solitude; others compulsively reenact dangerous relationships (Najavits 2002*b*). Alternating between the experience of feeling overwhelmed and shutting down, women come to treatment profoundly discouraged about the value and safety of relationships. For a client, safety is psychological and physical, internal and external. A major goal of treatment is to develop a therapeutic alliance. Ideally this alliance creates a safe place within which the woman can learn to trust and have new, meaningful experiences. For a substance abuse treatment program, safety is an organizational or system issue that calls for counselor readiness, collaboration with the client, staff training and supervision, and continual self-assessment of strengths and limitations (Markoff et al. 2005).
- *Tracking level of distress.* Counselors need to monitor their own and their clients' level

of distress. Counselors must observe the client for signs of discomfort. For example, if a client is hyperventilating, the counselor needs to help the client gain mastery of her breathing before proceeding. Using a scale of 1 to 100 to measure the client's subjective units of distress (SUD scale) can be a helpful tool in assessing the client's perception of current distress and in comparing her levels of distress from one session to the next (Wolpe 1969). It also provides tangible feedback to both the counselor and client.

- *Regulation of level of closeness and distance*. Carefully maintained boundaries between the counselor and the client maximize the effectiveness of the therapeutic relationship and ensure that treatment does not re-create the original trauma. For example, counselors should not physically intrude on a client who is "shut down"—does not want to be touched.
- *Timing and pacing*. The counselor addresses trauma issues when the woman is ready and functioning at a level where it is safe for her to explore the trauma; timing is directed by the client. The counselor helps the client identify when she is beginning to feel overwhelmed and how she can slow the process down. Trauma treatment begins with the start of substance abuse treatment and needs to be conducted in a careful and clinically sensitive manner. It is not always clear when and under what conditions it is helpful to a client to tell her trauma story. Sometimes results of this work are positive, but the telling can be harmful when the client does not yet have coping resources to handle the intense telling. Recalling or talking about her traumatic experience can retraumatize a woman. Even if the client wishes to talk about her trauma, it may be unwise if she is in an unstable situation (Najavits 2002*a*) and does not have a support system or is in danger of decompensation.
- *Coping skills*. A client's knowledge of coping skills helps her manage symptoms and increases her self-sufficiency and self-efficacy. Counselors and programs need to incorporate skill development components—including problemsolving, assertiveness, anger management, communications, and anxiety management—along with stress inoculation and relaxation techniques. Clients need to focus on both disorders and their interactions. More insight-oriented therapeutic work occurs once clients have attained abstinence and control over PTSD symptoms (Najavits et al. 1996, 2002*a*). Therapy should help women learn to use more healthful methods of coping with negative feelings, interpersonal conflict, and physical discomfort (Stewart et al. 2000).
- *Affect regulation*. Counselors need to assist clients in learning how to increase their tolerance for affective distress. The feeling of jeopardy feels real for both the client and counselor. It is the challenge for the counselor to remain connected with the client during this crisis, neither becoming overwhelmed by the traumatic reenactment nor emotionally abandoning the client by withdrawing (Cramer 2002). Training to handle strong feelings is essential, as is clinical supervision. Like the client, the counselor may feel shame, incompetence, anxiety, and anger. Emotional support from colleagues and supervisors helps counselors avoid defensiveness, client blaming, detachment, secondary traumatic stress reactions, and burnout.
- *Listening skills*. A critical part of therapy for addressing trauma in substance abuse treatment is to help the client gain support and establish safety. Counselors need to be nonjudgmental, empathetic, and encouraging; creating an environment that validates the client's experience through listening and gentle guidance.
- *Acknowledgment of grief and mourning*. The client needs time to grieve many losses. While this grieving process begins from the outset of treatment, the intensity of grief reactions often rises as anxiety symptoms dissipate.
- *Case management*. Case managers or counselors can assist women with solving problems and crisis intervention, locating peer-support groups and afterhours support, and coordinating linkages with other agencies.
- *Triggering and retraumatization*. During treatment, triggering is unavoidable. A trigger sets off a memory of the trauma. It can be a noise, a television show, another

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

Models of recovery

Since the late 19th century, a number of experts have conceptualized recovery from trauma in stages, describing it in different terms but referring to the same process (Herman 1997). Most of the conceptualizations followed three stages. The first stage is stabilization, preventing further deterioration and ensuring symptom management. During the second stage trauma is remembered, reenacted, and worked through. Stage three is a return to normal, the time when the client can live with the memories of the trauma, and problems are controlled. In *Trauma and Recovery*, Herman (1997) describes trauma as a disease of disconnection and provides a three-stage model for recovery: safety, remembrance and mourning, and reconnection. During these stages, clients receive consistent support for recovery from their substance use disorders.

Stage 1: Safety

Female trauma survivors in early treatment for substance abuse typically need to be in an all-women group led by a female facilitator. "Survivors feel unsafe in their bodies. . . . They also feel unsafe in relation to other people" (Herman 1997, p. 160). Counselors can ensure that the environment is free of physical and sexual harassment and assess a woman's risk of domestic violence. Counselors teach women to feel safe internally by using self-soothing techniques to alleviate depression and anxiety rather than turning to drugs (Najavits et al. 1996). Women are helped to feel physically and emotionally safe in their relationships with their counselors. The counselor works to develop the client's trust and to help her make the connection between substance abuse and victimization (Hiebert-Murphy and Woytkiw

Advice to Clinicians: Retraumatization

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

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

SAMHSA's Women, Co-Occurring Disorders and Violence Study (WCDVS)

In 1998, SAMHSA funded sites in the United States to develop integrated services for women who were the victims of violence and diagnosed with co-occurring mental and substance abuse disorders; services were also available for these women's children. This 5-year study sought to compare more integrated treatment with non-integrated treatment for more than 2,000 women and yielded information on the effectiveness of the integrated services approach for women. WCDVS also addressed the interplay of substance use disorders, trauma, and mental illness and demonstrated the empowerment and healing that comes when female clients are involved directly in their care and recovery. Outcomes for women in the study improved more than the outcomes for those in the treatment-as-usual group when women had a voice in the planning, implementation, and delivery of their treatment and received counseling for all three conditions together.

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

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

Source: Becker and Gatz 2005; Salasin 2005

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

Stage 2: Remembrance and mourning

In this stage, women tell their stories of trauma. Women mourn the losses associated with their abuse and substance use (Hiebert-Murphy and Woytkiw 2000). More specifically, they mourn their old selves, which the trauma destroyed. Women stabilized in substance abuse treatment may be ready to begin Stage 2 trauma work. A counselor can address the high risk of relapse that exists in this phase through anticipation, planning, and self-soothing mechanisms (Najavits 2002*b*). Considerable clinical judgment is required in determining whether the client has adequate coping skills.

Stage 3: Reconnection

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

Note to Clinicians

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

Treatment programs and curricula for substance use disorders and trauma

The following trauma-specific curricula are designed to address treatment issues with women who have a history of trauma and trauma-related symptoms and substance abuse. These programs are mainly focused on establishing safety and support, providing psychoeducation, and developing coping strategies and skills surrounding the sequelae of trauma and substance use disorders (for review of integrated trauma treatment models see Finkelstein et al. 2004 and Moses et al. 2003).

The Addiction and Trauma Recovery Integration Model (ATRIUM; Miller and Guidry 2001): Based on Miller's Trauma Reenactment Model, ATRIUM is a 12-week program that integrates psychoeducational and expressive activities for individuals with trauma-related and substance use problems. The ATRIUM model assesses and intervenes at the body, mind, and spiritual levels and addresses issues linked to trauma and substance abuse experiences such as anxiety, sexuality/touch, self-harm, depression, anger, physical complaints and ailments, sleep problems, relationship challenges, and spiritual disconnection.

Beyond Trauma: A Healing Journey for Women and A Healing Journey: A Workbook for Women (Covington 2003a, b): The theme of this 11-session integrated program for trauma treatment is the connection between substance abuse and trauma in women's lives. It includes a psychoeducational component for teaching women about trauma and its effects on the inner self (thoughts, feelings, and beliefs) and the outer self (behavior and relationships, including parenting). The program emphasizes coping skills, cognitive–behavioral techniques, and expressive arts, and is based on the principles of relational therapy. It includes a facilitator's manual, participant's workbook, and videos.

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

Seeking Safety (Najavits 2000, 2002*b*, 2004, 2007): This manual-based, cognitive, behavioral, and interpersonal therapy model for substance use disorders and PTSD focuses on client safety. It can be conducted in individual or group formats. The manual includes 25 topics and is based on five principles:

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

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

Note to Clinicians

Key issues in treatment for trauma-related mental disorders have been how, when, and whether to encourage clients to address trauma intensively during the course of substance abuse treatment. Most clinicians believe that a woman needs to achieve a basic level of safety before moving on to detailed trauma processing. The counselor should consider carefully the client's level of readiness for this type of work; the client's symptoms may worsen if she engages prematurely in such exploration (Herman 1997). In one study, interventions were adapted to combine exposure therapy with the "Seeking Safety" program; clients with substance use disorders were encouraged to move in and out of trauma processing, balancing it with training in coping skills and building in specific safety parameters (Najavits et al. 2005).

group modality (Najavits et al. 1998); women in prison in a group modality (Zlotnick et al. 2003); low-income and mostly minority women in individual format (Hien et al. 2004); adolescent girls (Najavits et al. 2006); and women in a community mental health setting in group format (Holdcraft and Comtois 2002). In a study that targeted patient and counselor feedback (Brown et al. 2007), results show that clinicians and clients alike were satisfied and felt that the Seeking Safety program was relevant to the treatment program and clients' needs. Seeking Safety has been implemented in a variety of clinical programs in addition to these research studies.

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

Trauma Recovery and Empowerment Model (TREM; Harris and The Community Connections Trauma Work Group 1998): This 33-session group approach was developed by clinicians with considerable input from clients and includes survivor empowerment, power support, and techniques for self-soothing, boundary maintenance, and solving problems to be covered over 9 months. TREM assists women with the trauma recovery process and includes social skills training, psychoeducational and psychodynamic techniques, and peer support groups. Each section includes discussion questions, typical responses, and experiential exercises (Harris and The Community Connections Trauma Work Group 1998). TREM is being evaluated in several treatment settings. Preliminary studies showed symptom reduction and client satisfaction (Berley and Miller 2004).

Treating Addicted Survivors of Trauma (Evans and Sullivan 1995): Combining therapeutic approaches with a 12-Step approach to the treatment of substance use disorders, this model for treatment of survivors of childhood abuse who have substance use disorders is based on a medical view of substance abuse as illness. It assumes clients accept the 12-Step approach, uses the principle of safety first to drive all interventions, and has five stages to organize the selection and timing of treatment tactics: crisis, skills building, education, integration, and maintenance (Sullivan and Evans 1994).

Substance Dependent PTSD Therapy (SDPT; Triffleman 2000): This integrated approach showed positive outcomes in a small controlled pilot study that compared it with 12-Step facilitation therapy. SDPT is a 5-month, two-phased, individual CBT method using relapse prevention and coping skills training, psychoeducation, stress inoculation training, and exposure treatment for PTSD. Participants meet twice weekly. The use of the combined approaches for PTSD treatment techniques with clients with substance use disorders is notable. The first phase incorporates understanding and education about PTSD symptoms as part of the overall approach to abstinence. The second

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

Mood Disorders

Depression

Major depression is an intense, acute form of depression, often with physiological changes in such areas as sleep, appetite, energy level, and ability to think. Thought content includes feelings of worthlessness and suicidal ideation or plans, although older adults and people from some ethnic groups or cultures sometimes do not express this cognitive component. Major depression has severe, moderate, and mild variants. Even mild major depression is a serious mental disorder.

Major depressive episodes and dysthymia are present in nearly twice as many women as men for both lifetime and 12-month prevalence. Research suggests that women experience more chronicity of depression in comparison to men characterized by earlier onset of symptoms, poorer quality of life, greater social impairment, and greater familial history of mood disorders (Kornstein et al. 2000).

Although rates of depression among women of color in the general population are comparable with those for Caucasian women, the illness is more likely to be undiagnosed and untreated in the former group, according to the literature reviewed (Mazure et al. 2002). Depression may appear through somatic symptoms that are misinterpreted by providers. Of concern is the lack of compliance with treatment regimens using psychotropic medications by women of color, which is possibly related to side effects of the medication. In addition, the sense of loss associated with migration may contribute to high levels of depression among Hispanic/Latina and Asian and Pacific-Islander immigrant women. In a study examining the use of pediatric emergency services with a sample of Mexican- and Central-American immigrants in Los Angeles, the women reported high levels of mental distress (Zambrana et al. 1994). Somatic complaints are common among Hispanic/Latinas and can mask depression or other mental illness.

Women with substance use disorders and depression

Alcohol consumption and alcohol-related problems co-occur with depression more often in women than in men (Graham et al. 2007). Depression usually precedes alcohol abuse in women, whereas alcohol dependence usually comes first among men (Moscato et al. 1997). Two mechanisms have been suggested to explain the pattern among women: (1) alcohol is used to try to relieve the symptoms of depression, and (2) depression renders women less concerned about issues of health and safety, including alcohol consumption (Dixit and Crum 2000). For more in-depth information on depression, refer to the TIP 48 *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery* (CSAT 2008).

One study indicates that the risk for heavy drinking is higher among women with a history of depressive disorder than among women with no history of depression, and the risk for heavy drinking rises with increasing reports of depressive symptoms (Dixit and Crum 2000). Research suggests that genetic factors contribute to women's susceptibility to both disorders. Among treatment-seeking women, depression is positively correlated with craving (Zilberman et al. 2003). While craving is not consistently associated with relapse, clients who experience cravings express distress in managing and coping with them.

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

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

Substance abuse treatment and depression

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

SSRIs and other new generation antidepressants often are used because their improved side effect profile increases the likelihood of compliance (Zweben 1996). Women with depression may respond to a combination of psychotherapy and medication. CBT and interpersonal therapies (IPT) are evidence-based approaches in treating depression (Butler et al. 2006; deMello et al. 2005; Kuyken et al. 2007), and they can be used as an adjunct to medication or as a principal intervention for mild or moderate depression. For clients who are hesitant to use medications or when the use of medication is contraindicated, CBT and IPT are viable options but appear far less effective when depression is severe (Luty et al. 2007; Markowitz 2003).

Eating Disorders

Between 90 and 95 percent of those diagnosed with eating disorders are women (Hoek 1995), with as many as 5 percent of young women being affected (Frank et al. 1998). Studies have shown that bulimia affects between 2 and 5 percent of women, whereas anorexia is much less common (Frank et al. 1998). About 2 percent of the U.S. population has a binge eating disorder, and it occurs in 10 to 15 percent of mildly obese people (National Institute of Diabetes and Digestive and Kidney Diseases 2001). However, all measures of the prevalence of eating disorders are considered to be estimates by researchers because they represent only cases diagnosed in medical facilities. Women with eating disorders are skilled at concealing their disorders and many remain undiagnosed (Hoek and Van Hseken 2003). Common definitions of eating disorders and behaviors are defined in Figure 7-4.

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

Note to Clinicians

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

Figure 7-4
Common Definitions of Eating Disorders and Behaviors

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

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

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

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

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

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

Although anorexia is seen most often in young heterosexual Caucasian women, girls and women from all ethnic and racial groups have eating disorders and disordered eating at increasing rates. Often these women receive treatment for the accompanying symptoms of an eating disorder, such as depression, rather than for the disorder itself. When they are finally diagnosed, the disorder tends to be more severe (HHS, Office on Women's Health 2000). Overall, studies show that eating disorders are positively associated with all DSM-IV mood, anxiety, impulse-control, and substance use disorders regardless of age, gender, and race-ethnicity (Hudson et al. 2007).

Women with substance use and eating disorders

One study evaluating the role of eating disorder behaviors and its association with substance use (Piran and Robinson 2006) determined that as eating disorder behavior becomes more severe, the number of substance classes used increases as well. Specifically, severe bingeing was consistently associated with alcohol consumption, and dieting and purging was associated with stimulant and sleeping pills/sedative use. Herzog and colleagues found that 17 percent of women seeking treatment for either anorexia nervosa or bulimia nervosa had a lifetime drug use disorder (Herzog et al. 2006).

Overall, research indicates that substance abuse is accompanied more often by bulimia and bulimic behaviors than by anorexia (Bulik et al. 2004; Holderness et al. 1994; Ross-Durow and Boyd 2000). Nearly one third of women with a history of bulimia also have a history of alcohol abuse, and 13 percent have a history of alcohol dependence. Alcohol abuse and dependence have been found to be related to PTSD and major depressive disorder, which in turn were associated with bulimia. One study demonstrated that alcohol use disorders are highly prevalent among women with bulimia and that the presence of PTSD and depression increases the risk of alcohol abuse occurring (Dansky et al. 2000).

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

early recovery. Compulsive or binge eating bears a similarity to abuse of substances other than food and is correlated with depression, thoughts of suicide, and childhood sexual abuse. Women engaging in binge eating sometimes use food as a substitute addiction; others may overeat to compensate for the stress they experience in early abstinence. Elements of the eating disorder take the place of relapsing to the drug of choice (Ross 1993).

Eating disorders need to be viewed in a biopsychosocial context that addresses biological or organic factors, a social component (influence of media and other cultural images enforcing standards of slimness for women), and psychological issues. Eating disorders are correlated with growing up in dysfunctional families where substance abuse occurs (van Wormer and Askew 1997). A strong relationship exists between eating disorders and depression, self-inflicted violence, and suicidal tendencies (APA 2000*a*; Kuba and Hanchey 1991). Most women with eating disorders meet DSM-IV criteria for at least one personality disorder, such as borderline, histrionic, or obsessive–compulsive personality (Zerbe 1993).

Eating disorders are sometimes present before the onset of alcohol and drug problems and can be obscured by active substance use, or they may be inactive during periods of active drinking or drug abuse. Eating disorders can precede the onset of substance use disorders chronologically, follow them, or develop simultaneously (Bulik and Sullivan 1998). A history of bulimia, anorexia, or compulsive overeating could become a barrier to the successful treatment of a client's substance use disorder if the prior eating disorder goes undetected. Deprived of compulsive involvement with food, a woman may begin to abuse substances. During treatment for substance use, unbeknownst to the therapist, the disordered eating behavior may reappear. Because the eating disorder takes over the function of the substances by helping the client cope, a cycle can occur that never addresses the common and predisposing factors contributing to both problems. There may be success in that the substance use has stopped; however, this may be a result only of disordered eating or symptom substitution. This disordered use of food masks depression, anxiety, and other symptoms expected to surface during the treatment of substance use, leaving the therapist with no view of the woman's coping abilities without any compulsive and disordered behavior. Eating disorders may coexist with alcohol and drug consumption in other ways (John et al. 2006). Diuretics, laxatives, emetics, stimulants, heroin, tobacco, and thyroid hormone may be attractive to a woman with anorexia or bulimia because of their weight-loss potential or their ability to facilitate vomiting (Bulik and Sullivan 1998).

Substance abuse treatment and eating disorders

Therapeutic modalities include individual, group, and family therapies. A cognitive–behavioral approach is used to address the irrational thoughts that lead to disordered eating behaviors (van Wormer and Askew 1997). CBT has been effective for women with bulimia in reducing the frequency of binge/purge cycles and improving body image, mood, and social functioning. In some instances, the use of tricyclic antidepressants and selective serotonin reuptake inhibitors can improve short-term outcomes, but in all eating disorder cases, medical evaluation should be included (Carr and McNulty 2006; Raeburn 2002).

Interpersonal therapy has been used successfully with women with bulimia, and dialectical behavior therapy recently has begun to be used with this population (Raeburn 2002; Safer et al. 2001). Additional treatment approaches for women with eating disorders that can engage clients include psychoeducation, behavioral contracting, and nutrition monitoring (Frank et al. 1998).

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

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

Addressing Tobacco Use With Women in Treatment

Cigarette smoking is a major cause of lung cancer among women. Approximately 90 percent of all lung cancer deaths are attributable to smoking. Since 1950, lung cancer mortality rates for American women have increased an estimated 600 percent. In 1987, lung cancer surpassed breast cancer to become the leading cause of cancer death among American women. In 2000, about 27,000 more women died of lung cancer (67,600) than breast cancer (40,800; CDC 2001). In 2004, diseases caused by cigarette smoking killed an estimated 178,000 women in the United States. The three leading diseases were lung cancer (45,000), chronic lung disease (42,000), and heart disease (40,000; CDC 2005).

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

Advice to Clinicians: Women With Eating Disorders

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

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

Source: Bulik and Sullivan 1998; Rome 2003

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

However, research and experience since the mid-1980s has begun to challenge these assumptions (for review, see Prochaska et al. 2004; Sussman 2002). Research shows that quitting smoking does not jeopardize substance abuse recovery; that nicotine cessation interventions in substance abuse treatment are associated with an increase in long-term abstinence of alcohol and illicit drugs. Prochaska and colleagues (2004) examined outcomes of smoking cessation interventions in 19 randomized controlled trials with individuals both in current addiction treatment and in recovery. The researchers found striking interactions between smoking cessation and success in treatment for other drug abuse. Their first observation was that among both men and women, those who stopped smoking while also quitting other drug use showed higher success rates in abstinence from alcohol and other drugs, even though their rates of relapse to cigarette use was high.

Motivating women to stop smoking involves addressing their concerns about the difficulties and negative consequences of smoking cessation and bolstering their confidence to stop (Miller and Rollnick 2002). Women's motives for stopping smoking include their present health, their future health, and the effect of their smoking on the health of others. Women's concerns about quitting include believing stopping will be difficult, feeling tense and irritable if they quit, enjoying smoking too much to stop, expecting difficulty concentrating after quitting, and anticipating gaining considerable weight after stopping (Lando et al. 1991; Pomerleau et al. 2001). Studies have not consistently shown differences in relapse rates between men and women, yet women appear to have higher rates of relapse when they fail to adhere to pre-established quit dates (Borrelli et al. 2004). Among women, relapse is significantly related to weight gain, strong negative affect, history of depression, family history of smoking, unemployment, and a history of smoking cigarettes high in nicotine (Cooley et al. 2006; Hoffman et al. 2001; Swan and Denk 1987; Wetter et al. 1999).

Akin to other services, smoking cessation programs should be integrated into substance abuse treatment for women. Providers are encouraged to include smoking cessation in their clients' treatment plans, as this will help send a message to women that treatment providers care about their total health. Further, even temporary cessation from smoking (assisted with nicotine replacement therapy) may give women confidence about remaining abstinent from other substances, and there may be no other opportunity to help them quit smoking. In reviewing the common relapse risks among women, nicotine cessation programs should consider strategies (along with pharmacologic therapies), that address body image, nutritional counseling, and emotional regulation combined with CBTs that target cognitions, establish quit dates, and teach coping strategies to manage anticipated difficulties in maintaining abstinence.

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

- Require all treatment facilities to be smoke free, and provide nicotine cessation programs for employees as well.
- Provide onsite cessation services and include tobacco and nicotine issues as part of treatment planning.
- Train staff to address nicotine addiction. Substance abuse counseling skills already in place can be applied to help clients achieve and maintain smoking cessation.

- Base counseling sessions on professional guidelines for smoking cessation, such as those supported by the National Cancer Institute and the U.S. Public Health Service.
- Provide all clients access to pharmacotherapy as an aid in quitting tobacco use; for example, nicotine patches and nasal sprays, bupropion (Zyban™), and varenicline (Chantix™), if medically appropriate. Note that few studies have examined the risks associated with nicotine replacement and other pharmacotherapies among pregnant women (for review, see Schnoll et al. 2007; Wise and Correia 2008).
- Identify local resources for referrals for more intensive interventions, such as the American Cancer Society (www.cancer.org) and the American Heart Association (www.americanheart.org).