

---

## CHAPTER I

---

# Introduction to Substance-Abuse Treatment for Women

In 1990, there were approximately 600,000 women in prisons or jails, on probation, and on parole in the United States. By 2001, the figure was over 1 million (Harrison & Beck, 2005). Although the rate of incarceration for women remains lower than the rate for men, the increase in the number of women imprisoned in the United States has been double the increase for men in the past quarter century.

Female prison populations have risen more quickly than male prison populations in all fifty states. Between 1995 and 2004, arrests for women increased by 13 percent while the number of women behind bars rose by 53 percent. Female imprisonment rates jumped 36 percent over the same period, compared to an increase of 17 percent for men (Greene & Pranis, 2006). The number of women serving sentences of more than a year grew by 757 percent between 1977 and 2004—nearly twice the 388 percent increase in the male prison population.

The reasons for the increased rate of imprisonment of women seem to be an increase in arrests of women for drug offenses, mandatory minimum sentences for many drug offenses, the building of new facilities for women, and an increase in non-violent property crimes by women during economic recessions (Belknap, Dunn, & Holsinger, 1997; Smith, Simonian, & Yarussi, 2006). “Instead of a policy of last resort, imprisonment has become the first-order response for a wide range of non-violent and petty offenses, and women have been disproportionately caught up in this trend” (Bloom, Chesney-Lind, & Owen, 1994, p. 2). Awareness of this has prompted a reexamination of correctional practices in order to determine the most effective way to respond to women offenders. This program is one way.

It is important for anyone who will be facilitating this program to understand the historical context of, and some of the obstacles to, substance-abuse treatment programs for women, particularly in criminal justice settings. It is also important to have an understanding of who the women are and a theoretical foundation for such work—an understanding of why we do what we do.

## Women in the Criminal Justice System: Who They Are

A basic principle of clinical work is to know who the client is and what she brings to the treatment setting. To be effective, a treatment program for substance-abusing women must address their specific strengths and needs. It is important to understand the typical life histories of female offenders, as well as the ways in which these contribute to substance abuse and a pattern of offending. This section presents a profile of women in the criminal justice system.

Most women in the criminal justice system are poor, undereducated, and unskilled, and they are disproportionately women of color. Many come from impoverished urban environments, were raised by single mothers, or were in foster-care placement. Women are more likely than men to have committed crimes in order to obtain money to purchase drugs. Some female addicts engage in prostitution as a way to support their drug habits, but it also is common for them to engage in property crimes. A national profile of women offenders (Bloom, Owen, & Covington, 2003) reveals the following facts.

### **They Are Primarily Members of Minority Groups**

Women offenders are disproportionately women of color. In 1999, a U.S. Government Accountability Office (GAO) study of the federal prison system in Washington, D.C., found that racial disparities were more pronounced for women than for men, with African American women being eight times more likely to be incarcerated than white women (U.S. GAO, 1999). Bureau of Justice Statistics (BJS) studies showed that, in 2003 and 2004, African American females were more than twice as likely to be in state prisons than Hispanic females. In 2003, they were nearly five times more likely than white females to be in state prisons, and in 2004, they were four times more likely (Harrison & Beck, 2004, 2005). Some studies have shown that race tends to correlate with increased sentence length (Bloom & Chesney-Lind, 2000).

## **They Have Committed Primarily Nonviolent Crimes and Most Often Were Convicted of Drug Offenses**

Most incarcerated women are addicted to alcohol or other drugs. They are less likely to have committed violent offenses and more likely to have been convicted of crimes involving alcohol, other drugs, or property. Although FBI data show a 6 percent increase in arrests of women for violent offenses between 1995 and 2004, data from the National Crime Victimization Survey show no significant increase in actual violent victimization by women for that period (Greene & Pranis, 2006). Many of the women who are in prison for violent crimes committed those crimes against spouses, ex-spouses, or boyfriends. They are likely to report having been physically or sexually abused, often by the persons they assaulted.

The vast majority of women's arrests are for lower-level offenses, with 82 percent falling into the less serious *non-index* category. This includes a large number of arrests for drug violations, as well as minor offenses typically thought to be "women's crimes," such as shoplifting and welfare fraud. Women account for more than 50 percent of arrests for commercial sex crimes, and more than 30 percent of incarcerated women have been charged with prostitution, commercialized vice, or drug offenses (Harrison & Beck, 2005).

## **They Are Poor, Not Well Educated, and Underemployed**

Most female inmates are poor. Many have high school degrees or GEDs but have limited vocational training and uneven work histories. More than 50 percent of mothers in state prisons and 38 percent of mothers in federal prisons were unemployed during the month before they were arrested. Of those who were employed, only 39.2 percent were employed full time (Mumola, 2000). The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 prohibited individuals with felony drug convictions from getting food stamps and Temporary Assistance for Needy Families, although it does not extend to convictions for murder or other violent crimes (Smith et al., 2006).

## **They Are Primary Caregivers of Young Children**

A majority of women offenders are in their early-to-mid-thirties, are single mothers, and have an average of two children each. In 1999, an estimated seven in ten women under correctional supervision had minor children. About two-thirds of women in state prisons and one-half of women in federal prisons lived with their young children

before entering prison. The number of children with incarcerated mothers nearly doubled between 1991 and 1999—from 64,000 to 126,000. Currently, it is estimated that 1.3 million minor children have a mother who is under correctional supervision (Mumola, 2000). Of all the mothers in state prisons, 54 percent reported that they had not had a personal visit with their children since their incarceration.

## **They Have Experienced Physical and/or Sexual Abuse as Children and Adults**

Seventy-seven to 90 percent of incarcerated women report extensive histories of emotional, physical, and sexual abuse as children and adults—far more than their male counterparts and more than women in the general population (Messina, Burdon, Hagopian, & Prendergast, 2006; Pollock, 2002). A BJS report found that 57.2 percent of women in state prisons, 39.9 percent of women in federal prisons, 47.6 percent of women in jails, and 40.4 percent of women on probation had been either sexually or physically abused (Harlow, 1999). Further studies have found that there is a link between poverty and histories of abuse in women (Browne & Bassuk, 1997). The abuse was most often committed by family members and intimates and often was associated with fragmented families, childhood foster-care placement, and parental abuse of alcohol or other drugs or parental criminal histories (Covington, 1998a, 2007a; Smith et al., 2006).

One of the most important developments in health care over the past several decades is the recognition that a history of serious traumatic experiences plays an often-unrecognized role in a woman's physical and mental health problems.

## **They Have Significant Physical and Mental Health Problems**

### **Physical Health**

A disproportionate number of incarcerated women come from low-income neighborhoods and did not have the transportation, child care, job flexibility, and money to access health care systems in their communities. They are an underserved population that often is disconnected from treatment services and information about prevention. Therefore, they enter the system with many medical problems, including chronic disorders associated with poor nutrition and poverty, such as asthma, obesity, diabetes, hypertension, anemia, seizures, and ulcers (Smith et al., 2006). In addition, drug-dependent women offenders are more likely than their male counterparts to suffer from tuberculosis, hepatitis, toxemia, anemia, hypertension, diabetes, and obesity (Messina & Grella, 2006).

Females also have health needs related to gynecological problems and prenatal and postpartum care. Women are at greater risk than men of entering prison with sexually transmitted infections (STIs) and HIV/AIDS because of their greater participation in prostitution and the likelihood of sexual abuse. Many STIs, if untreated, can lead to cervical cancer, secondary infections, infertility, and birth defects. In addition, imprisoned populations are at risk of contracting communicable diseases, particularly hepatitis A, B, and C; sexually transmitted infections (including HIV and AIDS); and tuberculosis (Smith et al., 2006).

### **Mental Health**

A recent study conducted by the BJS found that 73 percent of the women in state prisons and 75 percent of the women in local jails have symptoms of mental disorders, compared to 12 percent of the women in the general population. Three-quarters of the females who have a mental health problem also meet the criteria for substance dependence or abuse (James & Glaze, 2006). Addicted women are more likely to experience the following co-occurring disorders: depression, dissociation, post-traumatic stress disorder, other anxiety disorders, eating disorders, and personality disorders (Bloom & Covington, 2008). Surveys conducted among incarcerated women also have shown a strong link between childhood abuse and adult mental health problems, particularly depression, post-traumatic stress, panic, and eating disorders (Messina & Grella, 2006). Most incarcerated women with psychiatric disorders do not receive treatment (Teplin, Abram, & McClelland, 1996). There also is a growing body of evidence that incarcerated women are given more medication than are incarcerated men, and that it often is administered by untrained staff members in facilities with inadequate staff-patient ratios (Auerhahn & Leonard, 2000). Women with mental health problems who do not receive appropriate psychiatric treatment or counseling while incarcerated are at high risk for homelessness, violence, and repeated involvement in the criminal justice system (often to support their substance abuse) once they are released (Smith et al., 2006).

In summary, the females in our correctional systems are mostly young, poor, and undereducated women (and girls) of color who have complex histories of trauma and substance abuse. Most are nonviolent and are not threats to the community. Histories of physical and sexual abuse and poverty, as well as of substance abuse, are the most common pathways to crime for women. These women's greatest needs are multifaceted treatment for alcohol and other drug abuse, trauma recovery, and education in job and parenting skills. They need opportunities to learn, to grow, and to make changes in their lives (Covington & Bloom, 2006).

# Historical Background: Why a Woman's Treatment Program?

Research shows that (1) most female offenders need treatment for substance abuse and (2) there are distinct differences between males and females, including those in correctional settings. To determine the best treatment for women offenders, it is helpful to know about the history of substance-abuse treatment.

## The Secret

Not very long ago, nobody talked about incest, domestic violence, and women's addictions. Before the late 1960s, the fact that there were substance-abusing women was kept secret (Sandmaier, 1992). In the United States it was illegal to show a woman drinking in a movie or advertisement until the 1950s. That was not because women didn't drink but because people did not want to see women drinking. Decades after that, the public still recoiled when a famous woman admitted to having a drinking problem. Many people blamed newspapers for printing Betty Ford's announcement of her alcoholism, as though publicizing a woman's admission of addiction was shameful. When Kitty Dukakis acknowledged her drinking problem in 1988, some commentators blamed her for ruining her husband's campaign for the presidency.

Even today, although it is acceptable for women to drink, it is still not considered acceptable for women to abuse alcohol and other drugs. Families have far more denial about their sisters' and mothers' and daughters' substance abuse than they have about the addictions of the men in the family.

Cultures around the world have found ways to pretend that women don't abuse alcohol and other drugs. For example, a Finnish study found that physicians, employers, and judicial authorities were less likely to refer women for alcohol treatment than they were to refer men (Duckert, 1989). Yet even in cultures that prohibit it, women have found ways to use mood-altering substances. For example, among the Berber tribes of northern Morocco, such substances are taboo for religious reasons. It's not acceptable for women to drink, smoke, or use drugs, but eating is considered normal. So some women gather a small berry similar to the raspberry, ferment it, make it into jelly, and eat it. Similarly, in certain Zambian villages, the standard beverage for men is a home-brewed beer. The villagers will tell you emphatically that their women don't drink. However, the women brew the beer. Like women who are cooking anything, they stir and taste the beer throughout the day to see if it is ready. When it is brewed, it goes to the men, and the women start another batch. The women can taste half-brewed beer all day and remain high, while their intake remains invisible.

Surveys in the 1960s and 1970s repeatedly found that women and men of all socioeconomic classes considered drunkenness “worse” for a woman than for a man (Lawrence & Maxwell, 1962; Rachal, 1975; Sandmaier, 1992; Sterne & Pittman, 1972). This double standard continues to hinder women from receiving the help they need. Their own shame and their families’ shame about their addiction is often greater than it is for a man, which contributes to their denial.

The reluctance to acknowledge women’s substance abuse has hindered recognition of the patterns of such abuse and of women’s distinctive needs in recovery. “By 1970, only twenty-eight of the several hundred English-language alcoholism studies in existence specifically focused on the female sex” (Sandmaier, 1992, p. xv). As Greenfield (2006) pointed out, prior to the 1990s, substance-abuse treatment literature was based mostly on male samples or mixed-gender samples, with very little focus on gender differences, so it was not clear if “effective” substance-abuse treatments were generalizable to women. Women often were excluded from studies because of their childbearing potential or other factors. As late as 1992, “gender-disaggregated data for treatment outcomes continued to be relatively scarce” (Brown, 1995, p. 322). So even though we have known for decades that some women are addicted to alcohol and other drugs, smoking, gambling, sex, exercise, shopping, and so on, addiction research historically has focused on men, and treatment programs for both sexes have been based on research into men’s experiences.

## **Research and Practice from 1930 to 1960: A.A. and the Jellinek Curve**

In the 1930s, two men developed a recovery program for alcoholism that they called Alcoholics Anonymous (A.A.). For the first several decades of A.A.’s existence, women who attended the meetings were often invited to make coffee but not invited to raise issues unique to women. A.A.’s Twelve Step program proved successful for male, and some female, alcoholics and has become the standard for many kinds of mutual-help recovery groups.

The second cornerstone on which treatment programs were based was the research analysis of E. M. Jellinek, whose model of how people recover from addiction became known as the Jellinek Curve. In 1945, the *A.A. Grapevine* mailed about 1,600 questionnaires to recovering alcoholics, asking them to describe the process of their addiction and the process of their recovery. A.A. received only 158 responses, a very poor response rate, even by the standards of statisticians at the time. A.A. hired Dr. Jellinek to analyze and interpret the data, even though he remarked on their questionable validity. He found that the respondents diverged drastically into two groups. Ninety-eight respondents described their addiction and recovery in one way, and

about fifteen described theirs in a very different way (the other questionnaires were filled out improperly, so could not be used). The larger group was male, and the smaller group was female. Because the sample of fifteen women was too small to analyze separately, and because their data “differed so greatly” (Jellinek, 1946, p. 6) from that of the men, Jellinek threw out their responses and based his model on the men’s data. No one investigated further to see whether the women followed a distinct pattern of addiction and recovery. So, like A.A., the Jellinek Curve was based on the experiences of men. Women with addictions remained invisible.

## **New Insights in the 1960s and 1970s: The Women’s Movement**

One may wonder why societies around the world have avoided acknowledging women’s addictions and the reasons for those addictions. A partial answer is that if societies admit that women use substances to alter their moods, they will have to acknowledge other aspects of women’s experience that they would prefer to ignore, including physical abuse, sexual abuse, discrimination, and oppression. Women and their experiences will cease to be invisible, and the status quo will be threatened.

Something like that began to happen in the United States in the 1960s and 1970s. Some women began to talk in consciousness-raising groups about previously unmentionable subjects, such as incest, rape, violence, and the use of alcohol and other drugs to numb their pain. In 1976, Congress responded to pressure from feminist organizations and alcohol and drug constituency groups with legislation that funded specialized women’s treatment for the first time. The National Council on Alcoholism created a special office on women. The programs launched by these initiatives laid the foundation for our understanding of women’s treatment. These programs demonstrated that women would seek treatment when it was *holistic* (addressing a broad range of needs, from sexuality to violence to life-management skills), humanizing, long-term, and child-friendly—in short, when it was tailored to women. In the succeeding thirty years, we have built on these initial findings and developed a solid body of knowledge of promising practices for women’s treatment.

## **Therapeutic Communities**

Another way of thinking about substance abuse emerged in 1958 when Chuck and Betty Dederich founded Synanon. Chuck Dederich was an alcoholic and a former Gulf Oil executive who wanted a more challenging and interactive approach to sobriety than A.A. provided. He began hosting A.A. meetings with more discussion (cross-talk, or responding to someone else’s story with feedback, is discouraged in A.A. meetings). For economic reasons, recovering alcoholics began living together in what came

to be called a *therapeutic community*. In that community heroin addicts first entered recovery without medical intervention.

In 1963, Dr. Dan Casriel founded Daytop and began to spread therapeutic communities throughout New York and Europe. Dr. Mitch Rosenthal founded Phoenix House in 1967. The therapeutic-community model has been especially influential in correctional settings. Now nearly every state in the United States has at least one prison-based TC program, and many states have several. Studies with men have shown that TCs can positively affect recidivism rates (Eliason, 2006).

## The Confrontational Approach and Women

Despite scant research evidence of the effectiveness of TC programming for women, prisons and community correctional settings across the country continue to introduce new TC programs for women (Eliason, 2006). However, women's socialization patterns and the adverse consequences of trauma and abuse make the confrontational approach traditionally used in therapeutic communities ineffective with women and potentially harmful. Women require a different basis on which to build community: respect, mutuality, and compassion, rather than confrontation. An emphasis on assets and strengths, as opposed to tearing down the ego, has proven most effective with women. Therefore, therapeutic communities need to be modified for women. It is the essence of the therapeutic community that is important for women's services, not the structure.

## What We Have Learned

Addiction is a complex social and health problem that affects millions of women and girls every day. According to the National Center on Addiction and Substance Abuse (CASA), in 2003, 6 million women (ages twelve and older) were alcohol abusers or alcohol dependent, yet only 763,000 received treatment. That same year, 2.6 million women were abusing or dependent on illicit drugs, yet only 651,000 received treatment. This means that 84 percent of women and girls who needed treatment for alcohol and drug problems did not receive it (CASA, 2006).

Several years ago the United Nations developed a monograph on the treatment of drug-addicted women around the world. At a meeting of experts held in Vienna, it became clear that many of the issues that addicted women struggle with are universal:

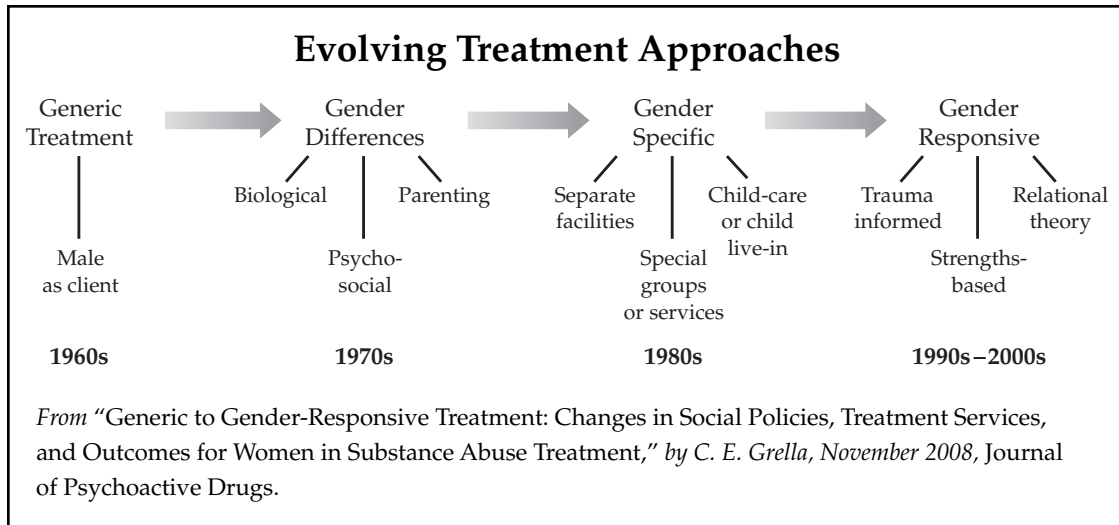
- Shame and stigma
- Physical and sexual abuse

- Relationship issues
  - Fear of losing children
  - Fear of losing a partner
  - Needing a partner's permission to obtain treatment
- Treatment issues
  - Lack of services for women
  - Not understanding women's treatment
  - Long waiting lists
  - Lack of child-care services
- Systematic issues
  - Lack of financial resources
  - Lack of clean and sober housing
  - Poorly coordinated services

Note that shame and stigma are still issues for women after more than forty years of acknowledging women's substance abuse.

However, we also are seeing significant changes. From 1998 to 2003, the federal Substance Abuse and Mental Health Services Administration funded the Women, Co-Occurring Disorders, and Violence Study. For two years, clinicians, program directors, researchers, consumers, and policymakers worked together to develop a consensus about integrated treatment for women. Then nine sites across the country were funded and participated in a research study. At both the six-month and twelve-month follow-up periods, advantages were found for women's integrated care (Cocozza, Jackson, Hennigan, Morrissey, Glover Reed, & Fallot, 2005; Morrissey, Jackson, Ellis, Amaro, Brown, & Najavits, 2005). The diagram on the following page helps to show the evolution of treatment approaches for women over time.

Currently, people in the substance-abuse treatment field are paying closer attention to the social, environmental, political, cultural, and economic contexts of women's lives and the intersection of these factors with psychological, biological, and chemical factors. The Office of Research on Women's Health, within the National Institutes of Health (2002), has issued its *Strategic Plan to Address Health Disparities Among Diverse Populations of Women*. It encourages researchers to include understudied women (for example, low-income women, women with disabilities, and lesbians) in their clinical trials, to study women who are at high risk for particular diseases and conditions, and to examine risk and protective factors among diverse groups of women.



## Gender Differences

There are differences between male and female substance abuse. *Stigma*, or severe social disapproval, is the main psychosocial issue that distinguishes women's substance abuse from men's. Although drinking-related behavior is often seen as "macho" in men, it conflicts with society's view of femininity, especially with the roles of wife and mother. For example, the sexual behavior of addicted men is rarely remarked on; addicted women often are labeled as "sluts." Women often internalize this stigma. They may feel guilt, shame, despair, and fear as they find themselves unable to control their behavior. Mothers know that they may lose their children if they fail to control their addictions. Because the stigma is shameful and threatening to the family unit, women and their families may use denial to protect the status quo.

The National Institute on Drug Abuse (NIDA) and other researchers have contributed to our knowledge of the differences between men and women who abuse substances. These are important aspects of women's addiction that have implications for treatment and should be known by counselors and others who treat addicted women.

- The effects of drugs are different for women and men. Women experience the adverse physiological effects of alcohol on the liver, cardiovascular, and gastrointestinal systems more quickly than men do—an outcome known as *telescoping* (Alexander, 1996).

- Nicotine, cocaine, and alcohol affect women's and men's brains differently. Women report greater feelings of physical and mental well-being after cocaine use than men do (NIDA, 2006).
- Women are less likely than men to be diagnosed with an alcohol or other drug problem in health care settings. Physicians often fail to accurately diagnose women who present with nervousness, anxiety, or depression (Brienza & Stein, 2002).
- Women are 48 percent more likely than men to be prescribed narcotic, antianxiety, and other potentially abusable drugs. The largest substance-abuse problem among older women is the misuse of prescription drugs (NIDA, 2001).
- Culture, race, and ethnicity affect the development of substance-abuse problems in women. When combined with lower income, less education, and unemployment, societal and institutional responses to culture and race can lead to feelings of alienation and powerlessness. Also, women of color experience more negative health and social consequences of substance abuse (Boyd, Phillips, & Dorsey, 2003) and are disproportionately represented among drug-addicted women convicted of drug crimes and sentenced to prison (Harrison & Beck, 2004).
- The pathway to drug use and abuse has a later onset and is more complex for women than for men and is more strongly linked to experiences of trauma and abuse. Women who abuse substances have higher rates of childhood and adult physical and sexual abuse than men and non-substance-abusing women do. These abuse experiences result in psychiatric disorders and symptoms that begin prior to drug use (Galaif, Stein, Newcomb, & Bernstein, 2001).
- Women who report childhood sexual abuse are more likely to develop drug addictions and then trade sex to support their drug habits. They are also more likely than nonabused women to feel they are unable to negotiate safer sex with partners. Thus, childhood victimization leads to a cascade of negative consequences for women that complicate addiction treatment (Cusick, Martin, & May, 2003).
- For women, the intersections among mental health, trauma, and substance abuse are critical issues. Co-occurring disorders, such as anxiety, depression, and other mood disorders, are more common among substance-abusing women than among substance-abusing men (Brady & Ashley, 2005).

- Women describe the onset of drug use as sudden and heavy, rather than gradual. It often occurs for a specific reason, such as depression or a family problem (Center for Substance Abuse Treatment, 1999).
- There typically is a breakdown of individual, familial, and environmental protective factors and an increase in childhood fears, anxieties, phobias, and failed relationships for addicted women (Felitti, 2002).
- The link between HIV/AIDS and drug use is greater in women. Nearly half of all women diagnosed with AIDS are injecting drug users (NIDA, 2000). In addition, significantly more women trade sex for drugs or money, increasing their risk for HIV/AIDS.
- A woman is more likely than a man to have been initiated into alcohol and other drug use by a (usually male) sexual partner and to continue to use drugs in order to feel connected to the partner and maintain the relationship. Women are more likely to have partners with addiction problems (Zelvin, 2002).
- Having a drug-using partner is a major barrier to entering treatment. Such partners are often the women's suppliers and resist the women's efforts to stop using drugs. Many women experience threats and intimidation from their partners if they attempt to seek treatment (Amaro & Hardy-Fanta, 1995).
- Female substance abusers tend to have minimal family support when entering treatment (Grella, Scott, Foss, Joshi, & Hser, 2003). When a woman decides to seek treatment, she faces different barriers than men do in finding and accessing services. Women are more likely to experience economic barriers to treatment, to report having trouble finding time to attend regular treatment sessions because of family responsibilities, and to have problems finding transportation (Brady & Ashley, 2005).
- Women and men are equally likely to complete treatment. However, women who complete treatment are nine times more likely to be abstinent than women who do not complete it, whereas men who complete treatment are only three times more likely to be abstinent than men who do not complete it (Green, Polen, & Lynch, 2004).
- Women have different relapse triggers than men. For example, men are more likely to relapse during "happy connecting" occasions, such as family reunions, engagements, marriages, and childbirth. Women are more likely to relapse in reaction to interpersonal loss such as death or separation (Straussner & Zelvin, 1997). A history of trauma and abuse also is a significant relapse trigger for women.

## Studies of Single-Gender and Mixed-Gender Groups

Research (Aries, 1976) suggests that, although men may benefit from coed groups, women benefit more from all-female groups.<sup>1</sup> In all-male groups, men say little about themselves, their key relationships, or their feelings. In all-female groups, women share a great deal about themselves, their feelings, and their relationships with lovers, friends, and family members. In mixed groups, men reveal much more about themselves and their feelings, while women reveal much less (Priyadarsini, 1986).

The amount of sharing differs as much as the content. In all-female groups, women strive to equalize the amount of time each woman talks; they draw one another out, fall silent after long speeches, speak up more after an absence or long silence, and avoid dominating the conversation. However, men tend to dominate in mixed-gender groups. Women tend to yield the floor to men and women take up only one-third of the time, even though they make up half the group. Men often punish women who fail to yield to them.

Women are much more supportive of one another in all-female groups than they are in mixed groups. Many women are socialized to compete with one another for male attention when men are present but will cooperate with one another when men are not present.

Aries found that, over time, women who were placed in both mixed and single-gender groups expressed a preference for the single-gender groups. Men, over time, preferred the mixed groups. These preferences make sense, given that mixed groups tended to expand the men's styles of relating while restricting the women's styles.

Aries studied high-functioning young men and women who were conversing about relatively nonthreatening topics. Women and girls who lack secure senses of self and have histories of abuse by males are even less likely to speak up on taboo topics, such as substance abuse, sexual abuse, and violence, when males are present. Women also may be uncomfortable discussing their mental health, sexual histories, relationships, child-care issues, and other personal topics with males present. In addition, many women believe that only women can understand how they feel and react to things. This is especially true of women who have been dominated by or abused by men in some way. Consequently, single-gender groups are essential for females.

Sometimes women say that they don't want to be in female-only groups, that they get along better with males. Women who say this usually get along with males by relying on being stereotypical females rather than expressing their true selves.

---

<sup>1</sup> Aries studied white, middle-class college students in the 1970s. We should be cautious in generalizing her results to persons of other races, classes, and ages, but other researchers have found similar results.

Also, females are more able to hide parts of themselves in a mixed group. In an all-female group, females tend to challenge one another's pretenses and denial; in a mixed group, females let one another get away with more because they understand the pressure to look good in front of males.

When a woman says, "I don't like women," she is also saying, "I don't like myself." Such a woman can benefit greatly from learning to trust and respect other women—and her own femaleness—in an environment in which there is no pressure to compete for male attention.

There is some debate among clinicians as to whether women-only groups are preferable for all women. In their review of the literature, McWilliams and Stein (1987) found that single-gender groups were the treatment of choice for certain clinical groups, including sexual-abuse survivors and battered wives or lovers. Herman (1992, 1997) also emphasizes that a trauma survivor who is working on stage-one recovery (safety) needs to be in a homogeneous recovery group. It is often difficult for women to talk in depth about physical or sexual abuse in front of men until they are ready for stage-three recovery (reconnection). Graham and Linehan (1987) found female-only groups to be preferable in dealing with chronic alcoholism. Bernardez (1978, 1983) points out that single-gender groups help women to develop assertiveness, redefine their understanding of feminine behavior, experiment with the balance between their own needs and those of others, and identify positively with other women. In contrast, Alonso (1987) says that mixed-gender groups offer females more alternatives to hyperfeminine personality traits and better represent the real world in which females live. In assessing Alonso's views, Fedele and Harrington (1990) conclude that single-gender and mixed-gender groups are appropriate for women at different stages of their lives. When a woman is at a stage of needing to consolidate experiences, ideas, feelings, and a sense of self (as in early substance-abuse recovery), a single-gender group is preferable. After her experience has been validated, she has more empathy for herself, and she is more empowered (as in later recovery), a mixed group may be appropriate for the next stage of her development.

So, although mixed groups may have their place in later, ongoing recovery, it is important that a gender-responsive treatment program for early substance-abuse recovery use single-gender groups. Recent research has shown that women are retained longer in women-only programs and in programs with higher concentrations of pregnant or parenting women (Grella, 1999; Grella, Joshi, & Hser, 2000). This is important because longer time in residential treatment was related to better post-treatment outcomes in three large-scale national studies (Greenfield et al., 2006). Findings from a meta-analysis also indicate that women benefit from being in a women-only program environment (Orwin, Francisco, & Bernichon, 2001).

## Women-Only Groups

Women tend to engage in group therapy more often than men. This phenomenon may be linked to gender norms that support the suppositions of the relational model. Groups encourage the development of a sense of belonging and connection to others, which helps to motivate women to stay in the process.

Many researchers and practitioners believe that the treatment needs of women with substance-use and mental health disorders are best met in women-only groups facilitated by women. When participating in a women-focused group, women generally feel more open and comfortable with a female facilitator (when discussing body-image issues, for example). Women's complex histories of sexual and physical abuse, the greater tendency toward social isolation, and the stronger stigma attached to women's substance abuse all call for treatment that could not take place in mixed-gender groups. Yet many community-based correctional programs continue to provide only coed services or consist of a group of people sitting in a circle doing individual work with a facilitator, without the benefit of the group process.

A cohesive group offers women unconditional acceptance, no matter what their histories or behaviors prior to the treatment experience. Support and emotional warmth provide the psychological glue that encourages risk taking for self-disclosure. The group process also provides insight and understanding. It attributes meaning to life's circumstances and validates each client's reality. The process allows each person to surface long-denied, powerful feelings, supported by acceptance from others. Group members begin to realize that feelings are not always overwhelming and that the imagined negative consequences of releasing their feelings do not occur (Yalom, 1995).

Finally, women-only groups afford women an opportunity to compare their attitudes about parents, partners, and children, and their feelings about things that have happened to them. The group members can suggest new possibilities for feeling, perceiving, and behaving.

Women-only groups should be respectful of men and include discussions on developing and maintaining healthy relationships with men, while acknowledging the need for focused attention on women's issues (Covington, 2007b).

## Fundamentals of Gender-Responsive Services

In this guide, I use the terms *woman centered* and *gender responsive* to describe recommended services for women. These terms indicate a specific approach:

*The creation of a treatment environment—through site selection, staff selection, program development, and program content and materials—that reflects an understanding of the realities of women’s lives and that addresses and responds to their challenges and strengths.*

The keys to developing effective treatment for women are acknowledging and understanding their life experiences and the impact of living as a woman in a male-based society. In other words, gender awareness must be part of the management, supervision, and treatment of women offenders in the criminal justice system.

In a research-based report for the National Institute of Corrections that states the guiding principles for working with women, gender is the first principle. A multidisciplinary review of the literature and research on women’s lives in the areas of substance abuse, trauma, health, education and training, mental health, and employment was conducted as part of this project (Bloom et al., 2003). The report’s guiding principles provide a blueprint for a gender-responsive approach to the development of criminal justice services.

- *Gender.* Acknowledge that gender makes a difference.
- *Environment.* Create an environment based on safety, respect, and dignity.
- *Relationships.* Develop policies, practices, and programs that are relational and that promote healthy connections to children, family members, significant others, and the community.
- *Services and supervision.* Address substance abuse, trauma, and mental health issues through comprehensive, integrated, and culturally relevant services and supervision.
- *Socioeconomic status.* Provide women with opportunities to improve their socioeconomic conditions.
- *Community.* Establish a system of comprehensive and collaborative community services.

(A complete copy of this report is available on line at <http://www.nicic.org/library/018017>.)

In order to develop gender-responsive treatment and services for women, it is essential to have a theoretical framework. Three fundamental theories for creating women’s services are addiction theory, relational-cultural theory, and trauma theory. These three theories create the foundation for *Helping Women Recover*. In addition, those who work with women in the criminal justice system should take a fourth theory into consideration, pathways theory.

## Pathways Theory

By understanding women's pathways into the criminal justice system, the hope is that we will develop ways to assist them to get out and stay out of it. Schwartz and Steffensmeier (2007) note how the "profound differences" between the lives of women and men shape their patterns of criminal offending. The research literature about women in the criminal justice system reveals distinct themes. Most of the women are members of minority groups and come from neighborhoods that are entrenched in poverty and largely lacking in effective social support. Some have been homeless. Alarming large numbers of these women have experienced very serious physical or sexual abuse, or both, often starting when they were young children and often committed by people with whom they had familial or other relationships. Women often have their first encounters with the law as juveniles who have run away from home to escape violence and physical or sexual abuse. Prostitution, property crime, and drug use can then become ways of life. As adults, most of these women are plagued with high levels of physical and mental health problems as well as substance-abuse issues. Finally, the great majority of these women are mothers—and they are far more likely than men in the criminal justice system to be the sole support and caregivers of their children.

## Addiction Theory: How Addiction Works and How Women Recover

The terms *substance abuse*, *chemical dependence*, and *addiction* often are used interchangeably, and there has been criticism of their lack of specificity. The model presented here works for both substance abusers and the chemically dependent. Further, the theory of addiction used in this treatment program is helpful regardless of where the female offender falls on the continuum of substance abuse and dependence.

### Models of Addiction

For generations, societies saw addiction as a moral issue (Sandmaier, 1992). The use of alcohol or other drugs and the things people did while using them were viewed as signs of something morally wrong with the user. Under this moral model, relapse is attributed to a lack of willpower or seen as a crime. The temperance movement and the "war on drugs" reflect this model.

In the 1950s, mental health professionals proposed a psychological alternative to the moral model of addiction: addiction was seen as a sign of an underlying psychological disorder. If one could somehow solve that disorder, the addiction would go away. Any loss of control while drinking or using other drugs was seen as temporary and secondary to a primary problem. If a person drank excessively to cope with other

difficulties, and then those difficulties were removed, the person would go back to drinking moderately.

Also in the 1950s, the chemical-dependence treatment field was born. Drawing on the work of A.A. and the Jellinek curve, practitioners outlined and advocated a disease model of addiction. They saw addiction as a primary condition with its own symptoms, not as a symptom of something else. They compared addiction to diabetes, a physical disease that carries no moral stigma. Neither addiction nor diabetes can be managed through willpower, and both require a person to maintain a lifestyle regimen for emotional and physical stability. Chemical-dependence practitioners also understood that the disease of alcoholism included not just physical but also emotional and spiritual dimensions. However, even if the diabetes analogy is useful, it often seems too individualistic and simplistic to adequately explain addiction in women's lives.

Today the addiction treatment field considers addiction a "chronic, progressive disease," although its treatment methods are more closely aligned to those of the emergency-medicine specialist (acute care) than the chronic-disease specialist (ongoing care) (White, Boyle, & Loveland, 2002). Recent articles assert that treating severe and chronic substance-use disorders through screening, assessment, admission, and brief treatment, followed by discharge and minimal aftercare, is ineffective and results in the shaming and punishing of clients for failing to respond to an intervention design that is inherently flawed.

An alternative to the acute-intervention model is *behavioral health recovery management* (BHRM). This concept grew out of *disease management* approaches to other chronic health problems; it focuses on quality-of-life outcomes as defined by the individual and family. It also offers a broader range of services earlier and extends treatment well beyond traditional (medical) services. BHRM models extend the current continuum of care for addiction by including (1) pretreatment (recovery-priming) services, (2) recovery mentoring through primary treatment, and (3) sustained, post-treatment, recovery-support services (White et al., 2002). BHRM is more aligned with the concepts of holistic health care, as the following list of guiding principles for BHRM, from Boyle, White, Corrigan, and Loveland (2005), shows.

1. Recovery Focus: Emphasize hope for high quality of life while managing recurring episodes of illness, client strengths and resilience.
2. Client Empowerment: Clients are involved in all aspects of service delivery and design.
3. De-stigmatization of Experience: Experiences with behavioral health disorders are normalized to the extent possible.

4. Evidence-based Interventions: Scientific evidence and broad professional consensus are used to inform interventions at all stages of treatment and recovery.
5. Service Integration: Multi-disciplinary, multi-agency models are used that integrate services previously provided in isolation from one another.
6. Recovery Partnership: The professional role shifts from purely a “treater” to a “recovery consultant” in partnership with the client. Emphasis on the long-term continuity of this relationship over time through various episodes of care.
7. Ecology of Recovery: The family and community systems are utilized extensively for long-term support of recovery. Multiple connections are promoted between the client and community systems to provide support for recovery.
8. Sustained Monitoring and Support: Flexible monitoring and easy re-engagement at an appropriate level of care, if necessary, is available, rather than a rigid, traditional “assess, admit, treat, discharge” process.
9. Continual Evaluation: Assessment and evaluation are continual throughout treatment episodes, as well as between and across episodes of care.

### **The Holistic Health Model of Addiction**

Alcoholics Anonymous (A.A.) was one of the first proponents of a holistic health model of addiction. Much of what has been learned about alcoholism has added to our understanding of the addictive process in general. Also, health professionals in many disciplines have revised their concepts of all diseases and have created a holistic view of health that acknowledges the physical, emotional, psychological, and spiritual aspects of disease.

In a truly holistic model, the environmental and sociopolitical aspects of disease are included. Woman-centered treatment has social-justice goals that are guided by knowledge about women’s lives, including women’s roles in society; how these affect their alcohol, drug, and tobacco use and problems related to that use; and how these factors can influence recovery (as, for example, barriers to treatment and self-help, retention, and relapse).

In using a holistic model of addiction (which is essentially a systems perspective), we try to understand every aspect—physical, emotional, and spiritual—of the woman’s self, as well as the environmental and sociopolitical aspects of her life, in

order to understand her addiction. We know that an addicted woman typically is not using alcohol or other drugs in isolation, so we take into account her relationships with her family members and other loved ones, her local community, and society. For example, even though a woman may have a strong genetic predisposition to addiction, it is important to understand that she may have grown up in an environment in which addiction and drug dealing are commonplace.

An integration of BHRM and the holistic health model of addiction is the most effective theoretical framework for developing treatment services for women because it is multidimensional. It allows clinicians to treat addiction as the primary problem while also addressing the complexity of issues that women bring to treatment: genetic predispositions, health consequences, shame, isolation, histories of abuse, or a combination of these.

Such an approach is consistent with the findings of twenty-five years of research by the National Institute on Drug Abuse (NIDA) and the Center for Substance Abuse Treatment (CSAT). Research indicates that drug addiction is a brain disease that disrupts the mechanisms responsible for generating, modulating, and controlling cognitive, emotional, and social behavior (Leshner, 1998). NIDA research also shows that drugs affect women's and men's brains differently (NIDA, 2006). Addiction is a progressive disease, with the severity of biological, psychological, and social problems increasing over time (CSAT, 1994).

Although there are different theories about why women become addicted to alcohol and other drugs, it is important to know that addiction is the result of many influences. Using the holistic model, we can describe the many dimensions of addiction for women as follows (Covington, 2007b, pp. 21–22):

*Physical.* The physical dimension of addiction is the way in which women's bodies are harmed by drug use and become dependent on drugs. These include changes in the brain's chemistry and functions that occur with chronic drug use.

*Psychological.* One important psychological dimension of addiction is denial about alcohol or drug use. When a woman does not see or admit to a problem, she is unable to seek the treatment she needs to recover. Denial can be a way of coping with a self-image or behavior that one doesn't like.

*Emotional.* This dimension of addiction involves a woman's expression of emotions. Some women have difficulty containing their emotions; others have difficulty expressing them. Women may use alcohol or other drugs in order to deal with emotional pain. Eventually, a woman's strongest emotional attachment may be to her drug of choice.

*Behavioral.* The behavioral dimension includes the high-risk actions women engage in to get their drugs of choice. It also refers to the high-risk actions they take when under the influences of mood-altering substances.

*Spiritual.* The spiritual dimension refers to the negative impact that alcohol and other drugs have on a woman's awareness and connection to herself, others, and the world around her.

*Environmental.* The environmental dimension involves the family, friends, groups, and social networks that surround women. This often includes people who support women's drug-use behaviors and lead them back to their drugs of choice.

*Sociopolitical.* The sociopolitical dimension includes society's negative stereotypes of and labels for women who are addicted to alcohol and other drugs. This directly impacts women's fears of disclosing their problems with alcohol and other drugs.

In summary, the treatment model presented here views chemical dependence as a disease, but from a holistic rather than a traditional (and limited) medical model. It is based on the belief that there are physical, psychological, emotional, spiritual, and even environmental and sociopolitical dimensions to the problem. Persons are not blamed for having the problem of addiction, but they are expected to resolve the problem with help from a variety of sources. Both the individual addict and the society that fosters addiction are addressed.

This holistic disease model is consistent with the public health model of disease in which the agent, the person, and the environment are all considered important factors. This treatment model, developed by the author, is called Women's Integrated Treatment (WIT). The WIT model is based on (1) the definition of and principles for gender-responsive services, (2) an integrated theoretical foundation (the pathways and addiction theories, as well as theories of psychological development and trauma [to be discussed]), and (3) multidimensional therapeutic interventions.

The basic elements and principles of woman-centered treatment are represented in the diagram on the following page. These elements are consistent with the definition of and the National Institute of Corrections principles for gender-responsive services.

### **The Spiral of Addiction and Recovery**

In addition to seeing addiction holistically, we can envision the process of addiction and recovery as a spiral. The downward spiral of addiction revolves around the drug of

## A Woman-Centered Framework for Treatment

### Participatory

- Involves women and their health care providers in an interactive process defined by mutual respect and collaboration
- Recognizes that women have authority over their own lives

### Empowering

- Promotes and strengthens sources of individual, group, and environment resilience
- Considers women as informed participants in their own health care with the right to control their own bodies
- Supports women's learning from and with each other
- Recognizes and builds on women's strengths
- Teaches women advocacy skills
- Provides women with the means for continued growth through education and training

### Respectful of Diversity

- Recognizes the impact of
  - Culture, language, disability, age, and sexual orientation
  - Geography, financial, and informational constraints
  - Social, economic, environmental, and other living conditions of women's lives
- Provides culturally competent care

### Social Justice Focus

- Encourages full participation by women in health service and program planning, evaluation, policy, and research
- Supports the involvement of service providers and all women in advocating for women's achievement of political, cultural, social, and economic equality

### Woman-Centered Care

### Safe

- Establishes emotionally, spiritually, culturally, and physically safe environments
- Incorporates approaches that actively take into consideration the likelihood of women's experience of violence

### Relational

- Addresses relational barriers to recovery
- Addresses needs of families and children

### Individualized

- Takes into consideration health concerns unique to each woman and her personal experiences, including her experience of violence and her roles as home-maker, worker, and caregiver
- Is sequenced by levels of readiness, goals, and priorities

### Comprehensive

- Recognizes linkages among physical, emotional, spiritual, and cultural aspects of women's lives
- Supports increased collaboration and partnering across health sectors, disciplines, and professions
- Supports use of alternatives and complementary therapies
- Involves comprehensive care, including health promotion, disease prevention, treatment, and rehabilitation

### Holistic

- Applies knowledge of biopsychosocial and spiritual factors in providing comprehensive care

*From Fetal Alcohol Syndrome and Women's Health: Setting a Women-Centered Research Agenda, by L. Greaves, N. Poole, and R. Cormier, 2002. Vancouver: British Columbia Centre of Excellence for Women's Health. Reprinted with permission.*

choice. Addiction pulls the addict into ever-tighter circles, constricting her life until she is completely focused on the drug. The object of her addiction becomes the organizing principle of her life. Using alcohol or other drugs, protecting her supply, hiding her addiction from others, and cultivating her love-hate relationship with her drug begin to dominate her world. The graphic on the following page helps us to visualize this process.

When a woman is in this downward phase of constriction, the therapist's task is to break through her denial. She must come to a point of transition, in which she shifts her perceptions in two ways. She must shift from believing "I am in control" to admitting "I am not in control." She must stop believing "I am not an addict" and admit "I am an addict" (Brown, 1985, p. 34).

Both shifts can feel humiliating. Our society's double standard inflicts far more shame on a woman who has an addiction than on a man who does. Although society may stigmatize a male addict as a bum, it rarely criticizes his sexual behavior or his competence as a parent. We must understand that a woman who enters treatment may come with a heavy burden of shame. She does not need to be shamed further; rather, she needs to be offered the hope that she can recover.

The upward spiral of recovery revolves around the drug in ever-widening circles, as the addiction loosens its grip and the woman's world expands away from the drug. Her world grows to include healthy relationships, an expanded self-concept, and a richer sexual and spiritual life.

Notice that the process is not merely one of turning around and ascending the same spiral but one of transformation, so that one ascends a different spiral. When women speak of recovery, they speak of a fundamental transformation: "I'm not the same person. I'm different than I was."

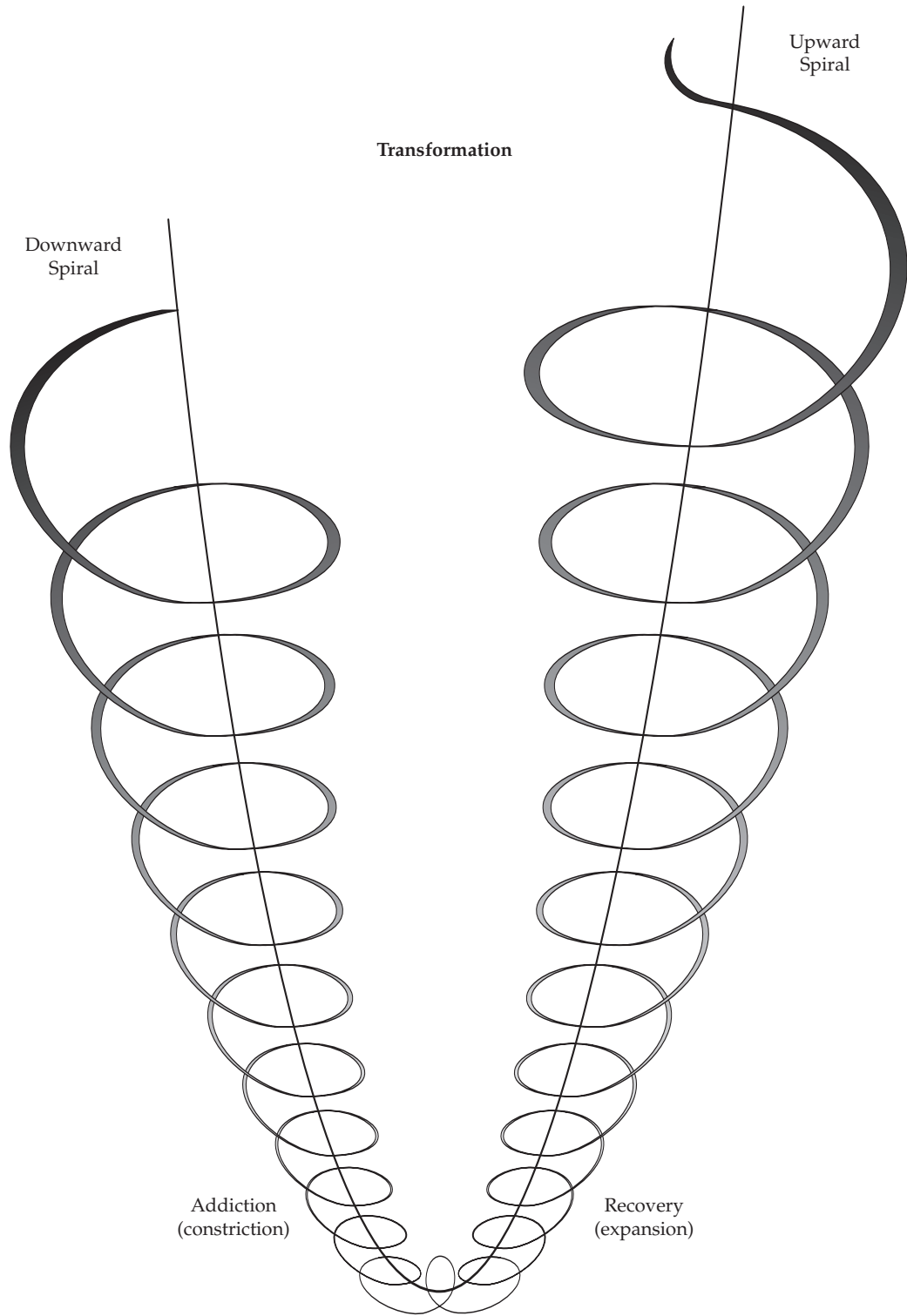
### **Addiction Defined as Neglect of Self**

The definition of addiction that I have developed and use for this program is

*A chronic neglect of self in favor of something or someone else.*

Practitioners who have studied men often see addicts as self-focused and perceive their task as breaking that obsession with self. Men who are addicted typically build up grandiose false selves that must be challenged before they can discover and cultivate their true selves. Addicted women, however, generally have diminished concepts of themselves. They have learned to negate and neglect their true selves in favor of other people and their drug(s) of choice. Both male and female addicts may appear self-obsessed because their lives are constricted around their drugs, while healthy give-and-take with others recedes into the background. However, their obsessions with their drugs hide their true selves.

# The Spiral of Addiction and Recovery



Questions then arise: How does a woman shift from a chronic neglect of self to a healthy care of self? How does a woman shift from constriction to expansion and growth? How does a woman grow and recover? How can we facilitate and support this process? These are the questions that this treatment program begins to answer.

## **Relational-Cultural Theory: Women's Psychological Development**

### **The Importance of Growth-Fostering Relationships**

Jean Baker Miller, a psychoanalyst, posed the question of how women grow and develop in her groundbreaking book *Toward a New Psychology of Women* (1976). Until its publication, traditional theories of psychology described development as a climb from childlike dependence to mature independence. A person's goal, according to these theories, was to become a self-sufficient, clearly differentiated, autonomous self. A person would spend his or her life separating and individuating until he or she reached maturity, at which point the person would be ready for intimacy.

Miller challenged the assumption that separation was the route to intimacy for everyone. She suggested that the theories might be describing men's experience, but that a woman's path to maturity was quite different. A woman's primary motivation, said Miller, is to build a sense of *connection* with others. A woman develops a sense of self and self-worth when her actions arise out of, and lead back into, connections with others. Connection, not separation, is the guiding principle of growth for women.

In 1978, Dr. Miller, along with three psychologists, Judith Jordan, Irene Stiver, and Janet Surrey, began meeting twice a month to reexamine developmental psychology and clinical practice (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991). Their meetings led to the creation of the Stone Center at Wellesley College for the purpose of exploring the qualities of relationships that foster healthy growth in women. According to the Stone Center's relational model, true connections are mutual, empathic, creative, energy releasing, and empowering for all participants. Such connections are so crucial for women that women's psychological problems can be traced to disconnections or violations within relationships—whether in families, with personal acquaintances, or in society at large (Miller, 1986). This theoretical approach is now called *relational-cultural theory* (RCT).

*Mutuality* means that each person in a relationship can represent her feelings, thoughts, and perceptions, and can both move with and be moved by the feelings, thoughts, and perceptions of the other person. Each person, as well as the relationship, can change and move forward because there is mutual influence and mutual responsiveness. *Empathy* "is a complex, highly developed ability to join with another at a cognitive and affective level without losing connection with one's own experi-

ence” (Covington & Surrey, 1997, p. 336). An empathic person feels personally authentic in the relationship and also feels that she knows the other person. Mutuality and empathy empower women, not with power over others but with power with others. Women feel more able to share power for constructive, creative ends. Mutual, empathic relationships are growth fostering and provide all participants with “five good things”: (1) increased zest and vitality, (2) empowerment to act, (3) knowledge of self and others, (4) self-worth, and (5) a desire for more connection (Miller, 1986).

RCT also explores the impact of disconnection, which is accompanied by diminishment of zest, empowerment, clarity, worth, and desire for connection. Disconnections happen at the sociocultural level, as well as the personal level, through racism, sexism, heterosexism, and classism. The issues of dominance and privilege are one aspect of relational-cultural theory (Jordan & Hartling, 2002).

Although RCT was developed to understand women’s psychological experiences, it is being used increasingly to gain a better understanding of all human experience, including men’s experience. Special attention is being paid to the importance of difference, particularly difference formed by imbalances in power and privilege. RCT is the foundation for a growing body of research on depression, trauma, eating disorders, substance abuse, chronic illness, mother-daughter relationships, lesbian relationships, racism, sexism, heterosexism, classism, and many other psychological and social problems (Hartling & Ly, 2000).

The program presented here is designed to foster mutual, empathic relationships among participants, and between leaders and participants, so as to cultivate what Miller describes as the “five good things.” It is an empowerment model.

In correctional settings, as in other places in society, it is a challenge to establish and maintain healthy friendships. Prison is a difficult place in which to nurture trust. Yet relational-cultural theory reveals that mutual, empathic friendships are essential to women’s growth. In fact, many women who are in prison strive to create whatever levels of relationship they can. Some build pseudo-families in which they relate like sisters, mothers, daughters, or lovers.

### **Addiction and Relationships**

From the perspective of the relational model, some women use alcohol and other drugs in order to make or keep connections. Finkelstein (1993) suggests that treatment planners who are designing programs for substance-abusing women need to take into account past family relationships; current relationships with family members, friends, and partners; and relationships developed within the treatment context. For example, researchers have identified five ways in which relationships with male partners can contribute to women’s substance abuse and hinder their recovery. First, male friends and partners often introduce women to drugs. Many women start using substances in

order to feel connected with addicted lovers, or they drink because their boyfriends urge them to. Then, whether or not a male partner first initiated a woman into drug use, he often is her supplier once she is addicted. Third, addicted women's lives are full of men who disappoint them, don't provide for their children, and in some cases, go to jail. These women long for the fathers of their children to provide emotional and financial support, but such longings often lead to disappointment and solace in drug use. Fourth, worse, many women report violence from the men in their lives. Drugs help to numb the pain of nonmutual, nonempathic, and violent relationships. Fifth, studies suggest that women receive less support from their partners for entering treatment than men receive from theirs (Amaro & Hardy-Fanta, 1995).

Additionally, women may use drugs in order to alter themselves so that they can fit into their available relationships. For example, a sexually dysfunctional woman may use alcohol to make herself able to engage in sex. Finally, nonmutual or abusive relationships produce what Miller (1990) calls a "depressive spiral": diminished zest or vitality, inability to act, confusion, diminished self-worth, and a turning away from relationships. Women may then turn to substances to provide what their relationships are not providing, such as energy, a sense of power, and relief from confusion.

Addicted women often speak of their addictions as relationships: "Alcohol was my true love; I never went to bed without Jack Daniels"; or "Food was my mother, my friend, my source of comfort." However, as the addiction progresses, women find that this friend becomes lethal: "I turned to Valium, but then Valium turned on me" (Covington & Surrey, 1997, p. 338).

Addiction is a relationship that constricts a woman's life. Our task in helping a woman to recover, then, is to help her to transfer her need for relationship to sources of growth-fostering connections, such as her counselor, her mutual-help group, and/or members of her recovery group.

### **Reparenting**

Growth in any dimension—cognitive, emotional, or sexual—is a process. Substance-abusing women often struggle with developmental issues for at least two reasons. First, they often come from dysfunctional families that did not support their growth. Their parents may have neglected them and left them to parent themselves, or their families may have abused them, leaving them traumatized. Second, addiction affects a woman's emotional and sexual development. It is not unusual for a woman in her thirties to seem emotionally and sexually adolescent if she became addicted in her teens.

One of the most common and basic developmental challenges for women is in developing a cohesive sense of self. Kohut (1984) theorized that, in order to develop a

cohesive sense of self, a child needs a parent to fulfill three functions. First, she needs a parent to *mirror* back her experience. The child falls down and cries, and the parent mirrors with a pained facial expression and empathic words, such as, “Ouch, that hurts, doesn’t it?” By mirroring her pain, the parent validates her experience. The child learns that her subjective feelings reflect something real. Second, the child needs to be able to *idealize* the parent. She needs to be able to see good qualities in the parent that she wants to adopt as part of herself. Finally, the child *twins* with her parent. She looks at her parent and says, “We’re alike. We both have dark, straight hair; we both like baseball.” In twinning, the child looks at the parent and sees not just a mirror for her emotions but a separate person who shares common traits. A child needs a parent to fulfill these three functions in the context of safety; mirroring, idealizing, and twinning cannot occur effectively when a child lives in terror of abuse.

Women who are in recovery often need to be reparented in order to develop a cohesive sense of self and to heal. A counselor, a correctional officer, a Twelve Step group, and a sponsor all can participate in reparenting. A woman also can learn to reparent herself in important ways. Both the facilitator and the other group members in this program can share in reparenting each member. For example, if the group members accept a woman’s reality without challenging it, they are mirroring her experience back to her. Twelve Step groups forbid cross-talk in order to safeguard the mirroring function of the group. Twelve Step groups also encourage members to choose sponsors who have qualities they like and want to adopt. The sponsor becomes someone to idealize. Members of Twelve Step groups acknowledge the twinning function in their groups with comments such as, “If you go to meetings long enough, someone will tell your story.” In this program, women may begin to idealize the facilitator and other women in the group. They also are likely to hear aspects of their own stories from the other women.

## Trauma Theory

The following statistics illustrate how pervasive interpersonal violence is in the lives of women and girls.

- The strongest risk factor for being a victim of partner violence is being female (American Psychological Association, 1996).
- Approximately 1.5 million women are raped or physically assaulted by an intimate partner each year in the United States. Because many are victimized more than once, approximately 4.8 million intimate partner rapes and physical assaults against women are committed annually (BJS, 2000).

- Women aged sixteen to twenty-four experience the highest per capita rates of intimate violence (19.6 victimizations per 1,000 women) (BJS, 2003).
- In 1998, over 1,800 murders in the United States were attributed to intimate partners. Three-quarters of the victims were women, accounting for 33 percent of all murders of women. Four percent of all murders of men were attributed to intimate partners (BJS, 2000).
- An estimated 67 of every 100,000 females in the United States were reported rape victims in 1998. Despite a decline in the nation's crime rate over the past decade, reported rates of rape and sexual assault did not decline (Federal Bureau of Investigation, 1999).
- Although relationship violence happens to women of every race and ethnic background, African American women are physically assaulted at a rate that is 35 percent higher than that of Caucasian women and about two and one-half times the rate of women of other races (Institute on Domestic Violence in the African American Community, 2007).
- Women in prison reported childhood abuse at a rate almost twice that of men; abuse of women as adults was eight times higher than the rate for men (Messina, Burdon, & Prendergast, 2003).
- Between 23 and 37 percent of female offenders reported that they had been physical or sexually abused before the age of eighteen (BJS, 1999).

A history of abuse drastically increases the likelihood that a woman will abuse alcohol and other drugs. In one of the first comparison studies of women who were alcoholics and women who were not (Covington & Kohen, 1984), 74 percent of the alcoholic women had experienced sexual abuse, 52 percent reported physical abuse, and 72 percent reported emotional abuse. In contrast, 50 percent of the women who were not alcoholics reported sexual abuse, 34 percent reported physical abuse, and 44 percent reported emotional abuse. "Moreover, the alcoholic women were found to have been abused sexually, physically, and emotionally by more perpetrators, more frequently, and for longer periods of time than their non-alcoholic counterparts. The alcoholic women also reported more incidents of incest and rape" (Covington & Surrey, 1997, p. 342). More recent studies confirm that the majority of substance-abusing women have experienced sexual or physical abuse, or both (Ouimette, Kimerling, Shaw, & Moos, 2000).

The connection between addiction and interpersonal violence is threefold: (1) substance-abusing men are often violent toward women and children; (2) substance-abusing women are particularly vulnerable targets for violence; and (3) childhood and current abuse increase a woman's risk of substance abuse (Miller, 1991).

Consequently, those who are planning and conducting any program for treating substance-abusing women must take into account that most will have suffered abuse and are trauma survivors (Covington, 1998b, 2007a). Trauma is not limited to suffering violence; it includes witnessing violence as well as stigmatization because of gender, race, poverty, incarceration, or sexual orientation. Many women who used to be considered *treatment failures* because they relapsed may now be understood as trauma survivors who returned to alcohol or other drugs in order to medicate the pain of trauma.

One way to clarify the meanings of *trauma* and *post-traumatic stress disorder* (PTSD) is to think of trauma as a response to violence or some other overwhelmingly negative experience. Trauma is both an event and a particular response to an event. The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (or *DSM-IV-TR*), of the American Psychiatric Association (2000) 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 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. The person’s response to the event must involve intense fear, helplessness or horror (or, in children, the response must involve disorganized or agitated behavior)” (p. 424).

PTSD is one type of disorder that results from trauma. The *DSM-IV-TR* lists the symptoms of PTSD (pp. 427–429) as follows:

- Reexperiencing the event through nightmares and flashbacks
- Avoidance of stimuli associated with the event
- Estrangement (the inability to be emotionally close to anyone)
- Numbing of general responsiveness (feeling nothing most of the time)
- Hypervigilance (constantly scanning one’s environment for danger, whether physical or emotional)
- Exaggerated startle response (a tendency to jump at loud noises or unexpected touch)

Symptoms of PTSD last more than thirty days and can recur later in life. The Adverse Childhood Experiences Study (Felitti et al., 1998) shows a strong link between childhood trauma and adult physical and mental health problems. Eight types of childhood traumatic events were assessed (emotional abuse and neglect, physical neglect, physical abuse, sexual abuse, family violence, parental separation/divorce, incarcerated family member, out-of-home placement). If a person experienced five of the eight types

of events in childhood, it increased the risk of both mental and physical health problems in that individual's adult life. This study was a model for research done on women in the criminal justice system. For women who experienced seven or more events, their risk of a mental health problem was increased by 980 percent (Messina & Grella, 2006).

A review of studies that examined the combined effects of post-traumatic stress disorder and substance abuse found more co-occurring mental disorders, medical problems, psychological symptoms, inpatient admissions, interpersonal problems, lower levels of functioning, poor compliance with aftercare and motivation for treatment, and other significant life problems (such as homelessness, HIV, domestic violence, and loss of custody of children) in women with both disorders than in women with PTSD or substance abuse alone (Najavits, Weiss, & Shaw, 1997).

Although PTSD is a common diagnosis associated with abuse and trauma, the most common mental health problem for women who are trauma survivors is depression. Of course, different women have different responses to violence and abuse. Some may respond without trauma, because they have coping skills that are effective for a specific event. Sometimes trauma occurs but is not recognized immediately, because the violent event is perceived as normal.

There is a difference between women and men in terms of their risk for physical and sexual abuse. Both female and male children are at risk in their childhood, from family members and people known to them. However, there are significant gender differences over a life span. In adolescence, boys are at risk if they are gay, young men of color, or gang members. Their greatest risk is from people who dislike or hate them. For a young woman, the greatest risk is in her relationships, from the person to whom she is saying, "I love you." For an adult man, the risk for abuse comes from being in combat or being a victim of crime. For an adult woman, the risk is again in her relationship with the person to whom she says, "I love you." Clinically, we think that this may account for the increase in mental health problems for women. It is more confusing and distressing to have the person who is supposed to love and care for you do harm to you than it is to be harmed by someone who dislikes you or is a stranger.

As the understanding of traumatic experiences increases among clinicians, mental health theories and practices are changing. It is important for service providers to understand trauma theory and to provide trauma-informed services for their clients. According to Harris and Fallot (2001), trauma-informed services do the following:

- Take the trauma into account.
- Avoid triggering trauma reactions or retraumatizing the woman.
- Adjust the behavior of counselors and staff members to support the woman's coping capacity.

- Allow survivors to manage their trauma symptoms successfully so that they are able to access, retain, and benefit from the services.

The second point is important because the standard operating practices in the criminal justice system (for example, searches, seclusion, and restraint) may traumatize or retraumatize women.

### **Three Stages of Trauma Recovery**

In *Trauma and Recovery* (1992, 1997), Judith Herman says that trauma is a disease of disconnection and that there are three stages of recovery: (1) safety, (2) remembrance and mourning, and (3) reconnection. These three stages are interdependent and usually do not occur in a linear fashion.

#### *Stage One: Safety*

The typical woman entering a substance-abuse treatment program is in stage one; her primary need is safety. In stage one, Herman says, “Survivors feel unsafe in their bodies. Their emotions and their thinking feel out of control. They also feel unsafe in relation to other people” (p. 160). Stage-one recovery focuses on self-care in the present. This program is based on stage one, so it is the stage to which facilitators of this program need to be most attuned.

Herman emphasizes that, for a woman trauma survivor who is working on safety issues, it is important that the group be composed solely of women and that the facilitator be female. Women may not want to talk in depth about physical or sexual abuse in groups that include men until they are ready for stage-three recovery. Herman cites Twelve Step groups as the type appropriate for stage-one recovery because of their focus on present-tense issues of self-care in a supportive, structured environment.

During stage one, a program should address the participants’ safety concerns in all the domains (cognitive/thoughts, affective/feelings, and relational/relationships) identified by Herman. This program includes sessions that discuss abuse, but the participants are not asked to recall or relate their specific incidences of abuse, and safety is a priority throughout the program. As Herman points out, it is inappropriate to work on memory retrieval while a woman is in stage one. A woman may need some stable recovery, a consistently safe external environment, a repertoire of self-soothing techniques, and a support system before she is ready to do memory work.

The facilitator can help the women in the group to feel safe by trying to keep the treatment program free of physical and sexual harassment. Safety is not guaranteed in the criminal justice setting, just as it is not guaranteed in the outside world, although a

few women have said that they felt safer in jail or prison than they felt on the streets or at home. Because abuse can occur inside prison as well as outside, a facilitator cannot ensure a woman's safety outside the group, but she can maintain an atmosphere of safety within the group.

Confidentiality is one essential aspect of safety in the group: what is said in the group remains in the group unless it involves a threat to someone's safety. In order to help ensure confidentiality, the facilitator may provide time in the group setting for women to do their journal activities. Afterward, the women may have the option of locking the journals up so that they need not worry about having them read by others between the group sessions.

Many trauma survivors use alcohol and other drugs to medicate their depression or anxiety because they know no better way to comfort themselves. The facilitator in this program will teach the participants to use self-soothing techniques (such as breathing, walking, listening to music, visualization, and meditation) rather than drugs. Because the women's trauma may have occurred in childhood, it may have caused developmental issues that can be partially addressed through reparenting.

Safety is so crucial for women in early recovery that it is referred to repeatedly throughout the program. It is important to recognize the lack of safety in many women's lives.

#### *Stage Two: Remembrance and Mourning*

A woman who is stabilized in her addiction treatment may be ready to begin stage-two trauma work. An example of a stage-two group is a survivors group. Stage-two recovery groups focus on the trauma that occurred in the past. The participants tell their stories of trauma and mourn their old selves, which the traumas destroyed. During this phase, women often begin to acknowledge the incredible amount of loss in their lives. Although the risk of relapse can be high during this phase, the risk can be minimized through anticipation, planning, and the reinforcement of self-soothing mechanisms.

#### *Stage Three: Reconnection*

Psychodynamically focused psychotherapy groups, which traditionally are unstructured and heterogeneous, reflect the third stage of recovery: reconnection. This stage focuses on developing a new self and creating a new future. For some women, this work can occur only after several years of recovery.

The group models appropriate to each stage are outlined in the following table.

<b>Three Group Models for Trauma Recovery</b>			
<b>Group</b>	<b>Stage of Recovery</b>		
	<b>One</b>	<b>Two</b>	<b>Three</b>
Therapeutic task	Safety	Remembrance and mourning	Reconnection
Time orientation	Present	Past	Present, future
Focus	Self-care	Trauma	Interpersonal relationships
Membership	Homogeneous	Homogeneous	Heterogeneous
Boundaries	Flexible, inclusive	Closed	Stable, slow turnover
Cohesion	Moderate	Very high	High
Conflict tolerance	Low	Low	High
Time limit	Open-ended or repeating	Fixed limit	Open-ended
Structure	Didactic	Goal-directed	Unstructured
Example	Twelve Step programs	Survivor group	Interpersonal psychotherapy group

*From Trauma and Recovery, by J. L. Herman, 1997. New York: BasicBooks. Copyright 1992, 1997 by BasicBooks, a division of HarperCollins Publishers Inc. Adapted with permission of BasicBooks, a division of HarperCollins Publishers, Inc.*

### **Trauma and Mothering**

Evidence collected over a number of years indicates that maternal substance abuse is a major contributing factor to child maltreatment. Addicted mothers are less often able to provide adequate shelter, care, and economic stability for their children. Further, the impaired judgment and emotional instability associated with substance abuse contribute to the risk of child abuse. Although estimates of the prevalence of substance-abuse problems among parents (the majority are mothers) who have contact with the child welfare system vary, the range is from half to 80 percent (Grella, Hser, & Huang, 2006).

What is less well understood is the impact of trauma on a woman's capacity to mother. The wounded mother is often the blamed mother. For many of these women, mothering means struggling to parent your child while at the same time struggling to recover.

A history of past trauma can affect how a woman experiences parenting and how effective she is as a parent. There are several major parenting issues for trauma survivors:

- Feelings of shame, guilt, and inadequacy can interfere with parenting.
- Interaction with a child can trigger a mother’s traumatic past.
- Mothers are at risk of becoming overprotective of their children.
- At the other extreme, mothers may be neglectful in order to avoid being “triggered” by their children.
- Addicted mothers may have been inadequately nurtured themselves.

Addiction programs for women who have children should include education in parenting and child development and interventions that address relationships with and reunification with their children. (See page 353 for parenting curricula.)

Many addicted women are more motivated to enter treatment and become abstinent when they become pregnant (Hankin, McCaul, & Heussner, 2000). This often is an opportune time to intervene with them. However, the challenge is for the woman to remain clean and sober after giving birth (Covington, 2007d).

## Integration

Women often have been expected to seek help for addiction, psychological disorders, and trauma from separate sources and to put together for themselves what they learned from a recovery group, a counselor, and a psychologist. As is noted earlier, one of the most important developments in health care is the recognition that serious traumatic experiences often play an unrecognized role in a woman’s physical and mental health problems.

The studies cited in this chapter indicate the need for an integrated approach, such as the Women’s Integrated Treatment (WIT) model, which is based on (1) the definition of and principles for gender-responsive services, (2) an integrated theoretical foundation, and (3) multidimensional therapeutic interventions. The *Helping Women Recover* curriculum embodies this comprehensive, gender-responsive model, so as to remove the burden of integration from women and increase their potential for recovery and healing.

Another curriculum based on this model is entitled *Beyond Trauma: A Healing Journey for Women* (Covington, 2003). It is a curriculum (with a manual and workbook) for women’s treatment based on theory, research, and clinical practice that can be used to deepen and build on the trauma work done in *Helping Women Recover*. The *Facilitator Guide* also provides more comprehensive information on working with women who are trauma survivors. Although the materials are trauma-specific, the connection

between trauma and substance abuse is recognized and integrated throughout the curriculum. The program is designed for use in outpatient, residential, and criminal justice settings. *Beyond Trauma* has a psychoeducational component that teaches women what trauma is, its process, and its impact on both the inner self (thoughts, feelings, beliefs, values) and the outer self (behavior and relationships, including parenting). The major emphasis is on coping skills, with specific activities for developing emotional wellness. The curriculum includes a facilitator manual, participant workbook, and three instructional videos or DVDs (two for facilitators, one for clients).

## The Value of Twelve Step Programs and Other Mutual-Help Groups

*Helping Women Recover* does not require that a woman participate in a mutual-help group, but facilitators may want to encourage the participants to attend such groups, either in addition to this program or after this program ends. There is a positive correlation between A.A. involvement and substance-use outcomes when treatment and A.A. are combined. Research at one- and three-year follow-ups found that people who attended treatment plus A.A. had significantly higher rates of moving from using to recovery than those who had treatment alone (Timko, Moos, Finney, & Lesar, 2000). A 1996 survey by the National Center on Addiction and Substance Abuse (1998) found that 74 percent of prison facilities offer mutual-help groups, mostly Alcoholics Anonymous, Narcotics Anonymous, and Rational Recovery. Most local jails also offer groups modeled on A.A. or N.A. Twelve Step groups provide a bridge back into the community for women who are leaving jails and prisons. Such a group creates a different kind of community from that available in institutions. It can expand women's sense of what support is possible. This resource is especially important in a time when money for substance-abuse treatment and psychological services is limited.

In addition to A.A., N.A., and C.A. (Cocaine Anonymous), there are at least 126 other Twelve Step groups for people who have other dependencies and for their families. Most are free and are readily available in most urban areas. Female-only meetings also are widely available. People are allowed to come and go without signing contracts or having records kept of their presence. Meeting formats are consistent, so a person can drop in on a new group and have confidence that the guidelines that make A.A. work will be adhered to. Most mutual-help groups in urban communities are available throughout most of the day. In this respect, they differ from most conventional therapies, in which help is provided only with an appointment, as a response to

a specific request from an individual. Such groups have replaced traditional therapy for many people; in fact, there are more women in A.A. than in professional treatment (Makela et al., 1996).

Certainly A.A. and the other groups have limitations. They stress individual change as the solution to a woman's problems and ignore social and political factors, such as male-dominated systems, that make life difficult for many women. Also, much of the Twelve Step literature is twenty to fifty years old and is "overtly sexist in its content and connotations" (Covington, 1991, p. 90). Atheistic, humanistic, and agnostic women may be uncomfortable with references to a "Higher Power," even though Twelve Step programs welcome a broad range of understandings of the higher power, including "Goddess," "Buddha," and a "Deeper Self."

Other mutual-help groups have been formed in recent years to address these limitations. Women For Sobriety groups resemble feminist consciousness-raising groups in which women discuss their lives from a female perspective. Save Our Selves groups follow a format similar to that of A.A. but omit references to a higher power in any form. SMART Recovery groups are available in the community and on line. Information on these groups may be found in the Appendix to this guide.

References to powerlessness in the first of A.A.'s Twelve Steps also concern many critics. They say that to ask women to admit their powerlessness over alcohol and other drugs and then over persons, places, and things is to encourage the women to think of themselves as victims who have no control over their lives. The recovery movement encourages individuals to surrender to a spiritual higher power, while the women's movement encourages people to join together to challenge and restructure power arrangements in society. However, masculine power over things is what is being relinquished in order to experience the feminine power with, the power to be able, or a personal sense of empowerment. French (1985) says that, "life is the highest value for 'feminine' people; whereas control is the highest value for 'masculine' people" (p. 93). This is the paradox of powerlessness: by admitting her powerlessness over alcohol and other drugs, a woman accesses areas of her life in which she does have power. For example, by admitting her powerlessness to change someone with whom she has a relationship, she is empowered to make decisions about how to relate to that person. A woman relinquishes a masculine-style "power over" things and people in order to experience a feminine "power with" or "power to be able" (Miller, 1982).

There also is confusion between the meanings of *surrender* and *submission*. "When we submit, we give in to a force that's trying to control us. When we surrender, we let go of our need to control" (Covington, 1994, p. 48). Recovery encourages surrender and giving up the illusion of control. Although the Twelve Steps are couched in terms that are more meaningful to men, many women are able to interpret them in ways that are meaningful and useful to them as well.

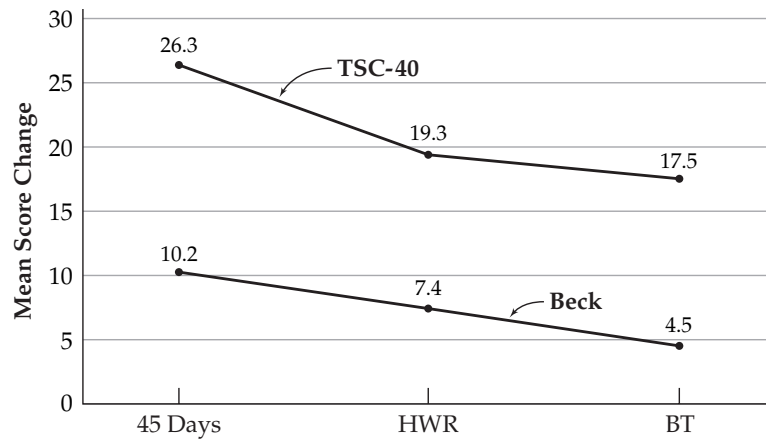
Mutual-help groups are not substitutes for professional counseling when a woman has been raped or battered or is the victim of incest. However, as part of a multifaceted support system, mutual-help groups can aid women in recovery. They provide the kind of safe environment that is needed for trauma recovery and a growth-fostering relational context that serves women's psychological development. Mutual-help groups offer a resource by which women may be grounded in a real community. They help set a foundation for a woman's understanding of what support, connection, and community can be like.

Many women have found the *A Woman's Way Through the Twelve Steps* book and workbook (Covington, 1994, 2000a) to be helpful when they are struggling to identify with the traditional masculine language of many groups. They find stories of other women's challenges and recoveries to be sources of hope. *A Woman's Way* explores such fundamental topics as spirituality, powerlessness, the emergence of a women's sense of the feminine soul, and other issues critical to a woman's recovery that are not discussed in coed meetings.

## Research on *Helping Women Recover*

*Helping Women Recover* currently is being evaluated at several sites. One completed evaluation, funded by the California Endowment, was conducted at a residential substance-abuse program for women and children. Pre- and post-tests were used with fifty women to evaluate the following domains: relapse, mental health symptoms related to trauma (anxiety, depression, PTSD), and family functioning (parenting skills and reunification). This study evaluated both *Helping Women Recover* and *Beyond Trauma*. The results indicated a decrease in depression and other trauma-related symptoms as well as less relapse. Overall, after participation in the *Helping Women Recover* and *Beyond Trauma* components of the treatment program, clients showed significant improvement in their level of trauma and depression (see the graph that follows). (The Beck Depression Scale and the Trauma Symptom Inventory were used to assess changes in the women's symptoms.) In addition to the significant ( $p < .05$ ) decrease in symptoms of depression and trauma, successful clients were more likely to report positive changes in other areas of their lives related to substance use, employment, and housing status. Almost all (99 percent) of the clients who successfully completed the program reported remaining conviction- and drug- and alcohol-free during the program. These results were similar to those of the twenty-nine clients who completed a six-month follow-up: 97 percent reported not having a new conviction and 72 percent reported not using any alcohol or drugs since exiting the program.

## Client Assessment Scores Improve After Completion of *Helping Women Recover (HWR)* and *Beyond Trauma (BT)*



From *Beyond Trauma: Providing Trauma-Informed Services to Women in Drug Treatment*, by C. Burke & S. Keaton, April 2007. *San Diego Association of Governments [SANDAG] Report*, San Diego, CA: SANDAG. For data, contact Sandy Keaton ([ske@sandag.org](mailto:ske@sandag.org)) or Cynthia Burke ([cbu@sandag.org](mailto:cbu@sandag.org)).

Additionally, nearly two-thirds (62 percent) of participants who came into the program unemployed left the program either employed, in school, or in employment preparation. For those clients who were available for follow-up, 83 percent reported being employed, in school, or in employment preparation. In addition, more clients reported living in a stable home environment at exit, with 60 percent of the clients owning or renting their residences, compared to 8 percent at intake. Thirty-nine percent reported living with a friend or relative. Only 1 percent lived in a jail or drug-treatment facility, and none were considered to be transient (for example, living in a car, park, or motel or on the street).

### Program Research in Progress

One prison-based pilot is using an experimental design with one hundred women randomly assigned to *Helping Women Recover* or to a standard prison therapeutic community (TC) program. The study is testing the impact of *Helping Women Recover* on program performance, aftercare participation, and recidivism for women offenders, compared to the impact of a standard TC. It also qualitatively assesses treatment staff and client perceptions of the elements of the program. It is anticipated that this pilot will be expanded to a five-year randomized study of 400 women using specific post-treatment outcome mea-

asures, including recidivism, substance abuse and relapse, and social adjustment (for example, employment, parenting behaviors, psychological improvement, relationship issues), compared to the impact of standard treatment. This two-year experimental pilot study is funded by the National Institutes of Health (IR21DA18699-01A1). Contact Nena Messina, Ph.D., at UCLA (nmessina@ucla.edu) for additional information.

Preliminary results (from a manuscript in preparation) indicate that women who participated in the woman-focused treatment groups are less likely than women who received the standard prison-based treatment to be back in prison at the time of the six-month follow-up interview. In addition, focus group data indicate that women in the woman-focused groups are more likely than women in the comparison group to perceive that their needs are being met and that their needs are understood.

The *Helping Women Recover* curriculum also is part of a large drug court study entitled Enhancing Substance Abuse Treatment and HIV Prevention for Women Offenders. It is funded by NIDA (1R01DA22149-01, September 1, 2006–August 31, 2009). This three-year study is a practice improvement grant that incorporates women-focused treatment into four program sites currently serving female drug court participants. An experimental component will determine the effectiveness of a women-focused treatment program based on *Helping Women Recover*, *Beyond Trauma*, and other Covington materials compared to standard, mixed-gender outpatient treatment for promoting positive behaviors among 150 women offenders (for example, HIV risk reduction, substance-abuse reduction, and increased psychological functioning).

Preliminary results indicate that women in the woman-focused groups have more treatment compliance and are less likely to have in-treatment drug court sanctions than women in the standard mixed-gender treatment groups. In addition, direct and written feedback from the participants in the woman-focused groups indicates that they feel the group is helping them in their path to recovery and that they are grateful they have been randomized to this specific group.

Contact Nena Messina, Ph.D., at UCLA (nmessina@ucla.edu), for further information on either of these studies.

## **Ongoing Canadian Research**

*Helping Women Recover* is the model chosen by Correctional Service of Canada for the development of its substance-abuse treatment programming for federally sentenced women. The Women Offender Substance Abuse Program (WOSAP) is a gender-responsive program based on relational-cultural theory and trauma theory and includes the areas of self, relationships, sexuality and spirituality. The ongoing research is showing both positive results for the women offenders and a positive response from the staff (Fortin, 2004).

