

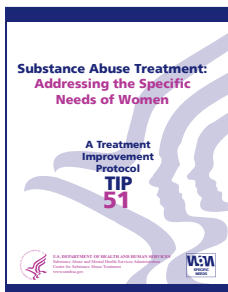
Quick Guide

For Clinicians

Based on TIP 51

Substance Abuse Treatment:

Addressing the Specific Needs Of Women



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Substance Abuse Treatment: Addressing the Specific Needs of Women

This Quick Guide is based entirely on information contained in TIP 51, published in 2009. No additional research has been conducted to update this topic since publication of TIP 51.

WHY A QUICK GUIDE?

This Quick Guide accompanies the treatment improvement guidelines set forth in *Substance Abuse Treatment: Addressing the Specific Needs of Women*, number 51 in the Treatment Improvement Protocol (TIP) series. It summarizes the how-to information in TIP 51 pertinent to behavioral health counselors and clinicians, focusing on tools, techniques, and concerns related to providing services to women with substance use disorders in behavioral health settings.

Users of this Quick Guide are invited to consult the primary source, TIP 51, for more information and a complete list of resources for addressing the needs of women who have substance use disorders. To order a copy or access the TIP online, see the inside back cover of this Guide.

DISCLAIMER: The opinions expressed herein are the views of the consensus panel members and do not necessarily reflect the official position of the Substance Abuse and Mental Health Services Administration (SAMHSA) or the U.S. Department of Health and Human Services (HHS). No official support of or endorsement by SAMHSA or HHS for these opinions or for the instruments or resources described are intended or should be inferred. The guidelines presented should not be considered substitutes for individualized client care and treatment decisions.

WHAT IS A TIP?

The TIP series provides professionals in behavioral health and related fields with consensus-based, field-reviewed guidelines on behavioral health topics of vital current interest. The TIP series is published by SAMHSA and has been in production since 1991.

TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women*:

- Discusses women’s patterns of substance use across a continuum from initiation of use through recovery.
- Identifies the physiological effects of alcohol, drugs, and tobacco on women.
- Focuses on specific screening, assessment, and treatment engagement, placement, and planning processes that support the unique constellation of women’s issues.
- Highlights women’s prevention issues and treatment needs across specific population groups and treatment settings.
- Synthesizes current knowledge, including science-based and best practices, to best address the biopsychosocial factors that influence treatment engagement, retention, and outcomes among women.

- Provides an overview of administrative considerations to support gender-responsive treatment for women.

Other TIPs of interest to readers include:

- TIP 25: *Substance Abuse Treatment and Domestic Violence*
- TIP 36: *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues*
- TIP 42: *Substance Abuse Treatment for Persons With Co-Occurring Disorders*
- TIP 43: *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*
- TIP 48: *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery*

Note: You may download TIPs and related products for free through the SAMHSA Store at <http://store.samhsa.gov>.

INTRODUCTION

Guidelines for Readers

This Quick Guide draws on ecological theory and the Center for Substance Abuse Treatment's (CSAT's) *Comprehensive Substance Abuse Treatment Model for Women and Children* (see Appendix B in the complete TIP). It is based on clinical practice and research centered on women. Rather than primarily comparing women with men, the knowledge, models, and strategies presented are grounded in women's experiences and their unique biopsychosocial and cultural needs.

The consensus panel recognizes that the realities of substance abuse treatment will sometimes preclude implementing the wide array of services and programs recommended in this Quick Guide. Nevertheless, by presenting a variety of techniques for addressing the specific treatment needs of women, the panel hopes to increase sensitivity to these needs and options for improving treatment.

Terminology

Gender. This term is used not just as a biological category, but also as a social category; society or culture shapes the definition of gender and shapes the socialization of each woman.

Gender-responsive. The content, delivery, and cultural orientation of gender-responsive (or woman-centered) services address the needs and characteristics of each woman. Particular consideration is given to the selection and development of the treatment setting and environment, staff, program components, and administrative and clinical policies and procedures. Overall, gender-responsive services reinforce healthy attitudes, behaviors, and lifestyles while appreciating the unique challenges and strengths of each woman.

Substance abuse. The term “substance abuse” refers to both substance abuse and substance dependence (as defined by the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*, American Psychiatric Association, 2000).

GENDER-RESPONSIVE TREATMENT PRINCIPLES

The principles articulated by the consensus panel are derived from research that highlights the distinctive characteristics and biopsychosocial issues associated with women in general and specifically with women who have substance use disorders.

These principles are as follows:

- **Acknowledge the importance and role of socioeconomic issues and differences among women.** Women's substance use and abuse should be framed in their socioeconomic contexts, including, but not limited to, employment, educational status, transportation, housing, literacy levels, and income.
- **Promote cultural competence specific to women.** Treatment professionals must understand the worldviews and experiences of women from diverse ethnic and cultural backgrounds, as well as the interactions among gender, culture, and substance use, to provide effective substance abuse treatment. Effective treatment depends equally on attention and sensitivity to the vast diversity among the female population, including overlapping identities of race, class, sexual orientation, age, national origin, marital status, disability, and religion.
- **Recognize the role and significance of relationships in women's lives.**

- **Address women’s unique health concerns.**

Women possess distinctive risk factors associated with onset of use, have greater propensity for health-related consequences from drug and alcohol consumption, exhibit higher risks for infectious diseases associated with drug use, and display greater frequency of various co-occurring disorders. Women who abuse substances are more likely to encounter problems associated with reproduction, including fetal effects from substance use during pregnancy, spontaneous abortion, infertility, and early onset of menopause.

- **Endorse a developmental perspective.** Generally, women experience unique life-course issues. One should consider age-specific and other developmental concerns starting with the assessment process and proceeding through continuing care and long-term recovery. Specific to women who abuse substances, these life-course issues, along with developmental milestones, influence their patterns of use, engagement in treatment, and recovery. Substance use and abuse affect women differently at different times in their lives.

- **Attend to the relevance and influence of various caregiver roles that women often assume throughout the course of their lives.** Regardless of substance abuse, women are more likely to assume primary caregiving responsibilities for their children, grandchildren, parents, and other

dependents. These roles may heavily influence a woman's willingness to seek help for substance abuse and also may interfere with her ability to fully engage in the treatment process or to comply with treatment recommendations.

- **Recognize that ascribed roles and gender expectations across cultures affect societal attitudes toward women who abuse substances.** Whether or not a woman neglects her role as a caregiver, engages in alcohol or drug-induced sexual activity, continues to use despite pregnancy, or uses sex to secure her next supply of drugs or alcohol, women with substance use disorders experience significant prejudice due to societal attitudes and stereotypes of women who drink and use drugs.
- **Adopt a trauma-informed perspective.** Current and past violence, victimization, and abuse greatly affect many women who abuse alcohol and drugs. Substance abuse treatment approaches need to help women find safety, develop effective coping strategies, and recover from the effects of trauma and violence.
- **Use a strengths-based model for women's treatment.** A strengths-based approach builds on the woman's strengths and uses available resources to develop and enhance resiliency and recovery skills, deepen her sense of competence, and improve the quality of her life. These strengths may include personality traits, abilities,

knowledge, cultural values, spirituality, and other assets; resources may involve supportive relationships and environments as well as professional support.

- **Incorporate an integrated and multidisciplinary approach to women’s treatment.** Treatment needs to integrate current knowledge, research, theory, experience, and treatment models from diverse disciplines critical to understanding women and substance abuse treatment. Treatment providers must network and collaborate with other agencies to provide comprehensive case management and treatment planning to address the complexity of biopsychosocial and cultural issues that women may exhibit throughout treatment.
- **Maintain a gender-responsive treatment environment across settings.** Women with substance use disorders are more likely to remain in treatment settings that feel familiar and safe, include their children, use proactive case management, and foster supportive relationships across the continuum of care.
- **Support the development of gender competence specific to women’s issues among clinicians, administrators, and other staff.** Administrative commitment and vigilance will ensure that staff members receive gender-specific training and supervision to promote the development of gender competence in providing services for women.

WOMEN'S BIOPSYCHOSOCIAL UNIQUENESS

Women with substance use disorders have unique biopsychosocial needs that should be addressed if their treatment is to be successful. The following information highlights these biological, psychological, social, and developmental factors.

Biological and Psychological

Women's physical responses to substances differ from those of men.

- Women have different physical responses to substances and typically display a quicker progression from initial use to the development of health-related problems.
- Women become intoxicated after drinking smaller quantities of alcohol than men. Women who drink are affected more by alcohol consumption due to higher blood alcohol concentrations, proportionately greater body fat, and less body water to dilute alcohol.
- Women develop substance use disorders and health-related problems in less time than do men, and this effect is known as telescoping.

Women with substance use disorders have greater susceptibility to as well as earlier onset of serious medical problems and disorders.

- From moderate to heavy use, drug and alcohol consumption increase specific health risks and physical disorders among women.
- Alcohol consumption increases risk for breast and other cancers, osteoporosis in premenopausal women, peripheral neuropathy, and cognitive impairment.
- Women develop cirrhosis and heart muscle and nerve damage with fewer years of heavy drinking than do men.
- Illicit drug use is associated with greater risk for liver and kidney diseases, bacterial infections, and opportunistic diseases.

Women who abuse substances have gynecological health issues and medical needs.

- Routine gynecological care is fundamental to the prevention or early detection of a variety of serious health problems among women with substance use disorders, including cervical, breast, and other cancers; HIV/AIDS; and other infectious diseases.
- Evidence supports the disruption substances cause in reproductive processes, such as the roles heavy alcohol use plays in infertility and drug use plays in menstrual cycles.

- In substance abuse treatment, many young and low-income women have never had a gynecological examination. Moreover, women over 40 with substance use disorders are less likely to have received a mammogram than other women of similar age.

In treating women of childbearing age who have a substance use disorder, pregnancy is a significant concern.

- Women who are abusing or are dependent on alcohol or other drugs may not realize they are pregnant.
- Women may mistakenly associate early signs of pregnancy as symptoms related to use of or withdrawal from substances.
- Often, women who are pregnant and using alcohol and illicit drugs do not begin prenatal care until well into their pregnancies, yet adequate prenatal care often defines the difference between routine and high-risk pregnancy and between good and bad pregnancy outcomes.
- Numerous medical concerns can result from substance use during pregnancy as well as from detoxification and the medications used to treat substance use disorders.

Women who abuse substances are more likely than other women to have co-occurring disorders.

- Women with substance use disorders are more likely to meet diagnostic criteria for mood disorders specific to depressive symptoms, agoraphobia with or without panic attacks, posttraumatic stress, and eating disorders.

Women who have substance use disorders are more likely to have been physically or sexually traumatized and subjected to interpersonal violence.

- A high proportion of women with substance use disorders have histories of trauma, often perpetrated by persons they both knew and trusted. These women may have experienced sexual or physical abuse or domestic violence, or they may have witnessed violence as children.
- Women who have been abused as children are more likely to report substance use disorders as adults.
- Physical and sexual dating violence are significant predictors of substance use.
- A reciprocal relationship exists between substance abuse and domestic violence; rates for one are higher in the presence of the other.

Social

Significant relationships and family history play integral roles in the initiation, pattern of use, and continuation of substance abuse for women.

- Women with alcohol use disorders are more likely than men to report having had alcohol-dependent parents, other alcohol-dependent relatives, and dysfunctional family patterns.
- Women are more likely to be introduced to and initiate alcohol and drug use through significant relationships, including boyfriends, spouses, partners, and family members.
- Women whose partners abuse substances exhibit greater substance use themselves, and they also have a higher incidence of substance use disorders.
- Women with substance use disorders are more likely to have intimate partners who also have substance use disorders.

Significant relationships and adult family members may substantially influence women's behavior associated with treatment seeking, support for recovery, and relapse.

- Women may have less support from family/partners than do men for seeking treatment.
- Women with alcohol problems are more likely to be left by their partners at the time of entry into treatment.

- Women's partners are less likely to stay with them after completion of treatment.
- Women are more likely to relapse due to interpersonal problems and conflicts, and relapse is more likely to occur in the presence of an unsupportive significant other.

For women, pregnancy, parenting, and child care influence alcohol and drug consumption and increase the likelihood of entering and completing substance abuse treatment.

- For many women, including those with substance use disorders, use of alcohol, tobacco, and/or illicit drugs significantly decreases after becoming aware of their pregnancy.
- It is common for women who abstained from alcohol, drugs, and tobacco during pregnancy to return to use after childbirth.
- If they are able to have their children in treatment, women are more likely to enter treatment, participate and stay in the program, and maintain abstinence.
- Women who are with their children in treatment have better treatment outcomes in major life areas than women who are without their children in treatment.
- Women in recovery see the support of their children as an essential ingredient for their recovery.

Women are more likely to encounter obstacles across the continuum of care as a result of caregiver roles, gender expectations, and socioeconomic hardships.

- Beyond pregnancy, women often assume many other caregiver roles that can significantly interfere with treatment engagement and regular attendance at treatment services.
- Of women who receive substance use treatment, about one third cannot cover treatment costs due to inadequate or nonexistent health insurance.
- Many female clients need transportation assistance; affordable, safe housing; and onsite child care and other services for their children.

Despite the unique challenges they face, women are more likely to engage in help-seeking behavior and to attend treatment after admission.

- Women with alcohol use disorders as well as drug use disorders of marked severity are at least as likely as men to initiate treatment.
- Once women are admitted to substance abuse treatment, they are at least as likely as men to participate and stay in treatment.

Women report more interpersonal stressful life events.

- Women report more interpersonal stress, whereas men report more legal and work-related stress.

- During the week prior to relapse and on the initial day of relapse, women report interpersonal problems and negative affect as key stressors.

Women often take different paths in accessing treatment for substance use disorders.

- Women are more likely than men to seek out physical and mental health treatment, including substance abuse treatment.
- Among women with substance use disorders, the most frequent source of referral to treatment is through self-referral; the next most frequent source is referral via the criminal justice system and other community referrals, including child protective services.

Women have unique client–counselor expectations and relational needs in treatment.

- Women are more likely to view relationship building as an essential treatment ingredient.
- Women are more likely to stay in treatment longer if they receive more intensive and individual care, can maintain their parenting role while in treatment, and stay within the same treatment services or maintain a connection with treatment providers throughout the continuum of services, including continuing care.

Women face unique types of discrimination related to substance abuse.

- Women who report not receiving or not perceiving a need for treatment attribute social prejudice as the primary reason.
- Some women fear negative consequences, including mandatory involvement with child protective services, loss of child custody, or other legal consequences if their substance abuse becomes known.

Developmental

Women experience unique life-course issues and events. Changes in physiology, emotional and social development, and cognitive capacity, as well as changes in social roles and expectations, have all been associated with substance abuse and its treatment.

Identity and gender expectations: The younger years

- During adolescence and young adulthood, young women are likely to face greater gender-based sociocultural expectations.
- The need to balance career endeavors—education, training, and employment—with caregiver responsibilities involving a woman's parents as well as her children is a major developmental task that is undertaken by women more often than men.

Caring for parents and partners

- More than 60 percent of caregivers are female.
- About 80 percent of informal elder care falls on family caregivers, and these caretaking responsibilities can last 10 years or more.
- Obstacles exist for women with substance use disorders—balancing the need to care for their parents and the need for their own substance abuse treatment.
- Women are more likely than men to outlive their partners.

The later years

- Substance abuse and dependence may exacerbate postmenopausal risks for coronary heart disease, osteoporosis, and breast cancer in women.
- Alcohol problems are ordinary events among the elderly, and estimates of the prevalence of heavy drinking or alcohol abuse range from 2 to 20 percent for this population.
- The etiology of elder substance use disorders is multifaceted, and spousal loss is one commonly cited factor.

FACTORS THAT PROTECT AGAINST THE DEVELOPMENT OF SUBSTANCE ABUSE AND DEPENDENCE

Partners

A good marriage can be protective against the development of alcohol abuse in women with a familial history of alcohol abuse.

Religious and Spiritual Practices

Higher levels of personal devotion, religious affiliation, and religious beliefs may reduce the risk for substance use and dependence among women.

Parental Warmth

Women who come from families that have high parental warmth are less likely to initiate use, abuse substances, or become dependent on alcohol or drugs.

Coping Skills

Engaging in problem-solving skills, mobilizing support from others, and learning to cope with one's feelings are key protective ingredients.

PATTERNS ASSOCIATED WITH WOMEN'S SUBSTANCE USE

- Women are affected by familial substance abuse as much as men; the prevalence of alcohol dependence among women whose parents use substances is from 10 to 50 times higher than prevalence among women who do not have a parent who abuses substances.
- Women who grew up in families where they took on adult responsibilities as children, including household duties, parenting of younger children, and emotional support of parents, are more likely to initiate drug and alcohol use.
- Women with partners who have alcohol-related problems are more likely to report mental health problems, including mood, anxiety, and quality-of-life problems, as well as substance use disorders.
- Women who are dependent on illicit drugs are more likely than their male counterparts to have partners who also use illicit drugs.
- Female adolescents and women struggling with either issues or prejudice surrounding sexual orientation are at greater risk of initiating and maintaining drug and alcohol use.
- Some women continue using alcohol and illicit drugs to have an activity in common with their partners or to maintain their relationships.

- Women are at risk of contracting HIV/AIDS and hepatitis from sharing needles or having sexual relations with men who inject drugs or have sex with men.
- A history of adverse childhood experiences and other traumatic events (e.g., sexual and physical assault, childhood sexual and physical abuse, domestic violence) is significantly associated with initiation of substance use and the development of substance use disorders among women.

Trauma is both a risk factor for and a consequence of substance abuse. Women with histories of trauma may be using substances to self-medicate symptoms. Thus, interventions should be immediately put into place to help build coping strategies to manage strong affect, including relaxation and other anxiety management skills. Start skills-building immediately rather than waiting for an incident to occur. It is far more difficult to manage symptoms when they are heightened than when they are at lower levels of intensity.

- Women are more likely than men to have co-occurring mental and substance use disorders.

- Anxiety disorders and major depression, the most common co-occurring diagnoses, are positively associated with substance use, abuse, and dependence among women.
- Women are more likely to be introduced to and initiate alcohol and drug use through significant relationships, including boyfriends, spouses, partners, and relatives.
- Even though women are less likely to inject drugs than men, they accelerate to injecting at a faster rate than men, and they are more likely than men who inject drugs for the first time to be introduced to this form of administration by a sexual partner.
- Drinking low to moderate levels of alcohol in early adulthood is a predictor of later heavy drinking and alcohol-related substance use disorders among women. Frequency of use appears positively associated with risk of alcohol dependence.
- Women are likely to curtail use of or establish abstinence from alcohol and illicit drugs while pregnant, even though they are as likely to resume use later on.
- Women experience an effect called telescoping, whereby they progress faster than men from initial use to alcohol- and drug-related consequences, even when using a similar or lesser amount of substances.

PHYSIOLOGICAL EFFECTS OF SUBSTANCES IN WOMEN

Physiological Effects of Alcohol Consumption

Women experience negative physical consequences and complications from alcohol sooner and at lower levels of consumption than men. Evidence suggests that women progress significantly faster in developing dependence, organ damage, and diseases, even with much lower levels of alcohol consumption. Women are more likely to die many years earlier from alcohol abuse and dependence.

Following is a selection of disorders and diseases associated with alcohol use among women.

Liver and other gastrointestinal disorders

- Fatty liver
- Alcohol hepatitis
- Cirrhosis
- Liver cancer
- Ulcers/gastritis
- Pancreatitis
- Diabetes

Heart-related conditions

- High blood pressure (hypertension)
- Cardiomyopathy
- Stroke
- Arrhythmia

Nutritional deficiencies

- Malnutrition
- Vitamin and mineral deficiencies

Reproductive consequences

- Fetal alcohol spectrum disorders (FASDs)
- Low birth weight
- Miscarriage
- Painful/irregular menstruation
- Underproduction of hormones

Cancers

- Breast
- Throat and mouth
- Stomach and colon

FASDs

Maternal alcohol use during pregnancy contributes to a wide range of effects on exposed offspring known as FASDs. FASDs are characterized by abnormal facial features, growth deficiencies, and central nervous system problems. Symptoms can include hyperactivity and attention problems, learning and memory deficits, and problems with social and emotional development. Despite alcohol-related birth defects being completely preventable, FASDs are the most commonly known nonhereditary causes of developmental disabilities.

Bone diseases

- Osteoporosis

Cognitive and other neurological effects

- Brain shrinkage
- Peripheral neuritis/neuropathy
- Dementia
- Wernicke's encephalopathy
- Korsakoff syndrome
- Cerebellar degeneration

Infections (greater susceptibility, faster progression)

- HIV/AIDS
- Tuberculosis
- Pneumonia

Physiological Effects of Drug Use

Research, although limited, suggests that women may be more vulnerable to the physiological effects of licit and illicit drugs and points to the existence of a gender-based vulnerability to the adverse consequences of substance dependence. Women report more severe psychiatric, medical, and employment complications than men, and there is evidence that women who use injection drugs are more susceptible to medical disorders and conditions. Similarly, women who use cocaine, heroin, or injection drugs have a heightened risk of developing herpes, pulmonary tuberculosis, and/or recurrent pneumonia.

CHARACTERISTICS OF TREATMENT ADMISSIONS AMONG WOMEN

- Women are less likely to report alcohol as their primary substance of abuse than men. Although alcohol is still the primary substance of abuse, women are more likely than men to be in treatment for drug use.
- Women who enter treatment are more likely to identify stress factors as their primary problem rather than substance use.
- Women exhibit more severity of and problems related to substance use upon entering substance abuse treatment, including medical and psychological problems.
- Women constitute about 30 percent of admissions for substance abuse. Depending on treatment level, admission rates vary from 29 percent in hospital inpatient facilities to 39 percent in outpatient methadone programs.
- Women are admitted in notable proportions for all types of prescription and over-the-counter drug abuse: 47 percent for prescription narcotics, 44 percent for prescription stimulants, 50 percent for tranquilizers, 51 percent for sedatives, and 42 percent for over-the-counter medications.
- Approximately 4 percent of women admitted to substance abuse treatment are pregnant at the time of admission.

Note to Clinicians

For a woman entering treatment, the tendency to focus on problems or stressors other than her substance abuse is quite normal:

- Women are socialized to assume more caregiver roles and to focus attention on others. Even if a woman has not appropriately cared for others (such as her children) during her addiction, it does not mean that she will not see this as an important issue immediately upon entering a detoxification or treatment program. Instead of assuming that the female client's worries and her tendency to be other-focused is a detriment or an issue of resistance for treatment, clinicians should use her concerns as a means of motivation throughout treatment.
- Depending on the specific drug class, some women may have considerable concerns regarding potential weight gain if they enter treatment and establish abstinence. Among women, weight loss is more likely to be seen as a major benefit in continuing drug use.
- In assessing risk factors or potential triggers for relapse, note that the initial reasons for use may be the same as reasons for relapse, even if initial use occurred many years ago. More times than not, women generally will underestimate the risks associated with these issues. For example, women who initiated use due to a relationship will often deny that relationships are a current risk factor.

SCREENING AND ASSESSMENT OF SUBSTANCE ABUSE AMONG WOMEN

How screenings and assessments are conducted is as important as the information gathered. Screening and assessment are often the initial contact between a woman and the treatment system. They can either help build a trusting relationship or create a deterrent to engaging in further services.

- Self-administered tools may be more likely to elicit honest answers, especially regarding questions related to drug and alcohol use.
- Face-to-face screening interviews have not always been successful in detecting alcohol and drug use in women, especially if the counselor is uncomfortable with the questions.
- Substance abuse screening and assessment tools, in general, are not as sensitive in identifying women with substance abuse problems.
- Screening and assessment instruments should be examined to determine if they were developed using female populations. If not, counselors need to explore whether or not there are other instruments that may be more suitable to address specific evaluation needs.
- Because women are more likely to experience greater consequences earlier than men, using an instrument that highlights specific consequences of use is crucial.

Trauma-Informed Screening and Assessment

Often, clients who have posttraumatic stress disorder (PTSD) have a difficult time distinguishing between past feelings of danger associated with trauma(s) and their current surroundings when discussing trauma-related material during interviews and counseling. Therefore, counselors must remember that discussing the occurrence or consequences of traumatic events and subsequent PTSD symptoms can feel as unsafe and dangerous to clients as if the event were occurring now. Although the counselor should try not to encourage avoidance or reinforce the belief that discussing trauma-related material is dangerous, sensitivity is needed when gathering information about a woman's history of trauma.

Initial questions about trauma should be general and gradual. Although ideally, the counselor will allow the client to control the level of disclosure, it is important to mediate the level of disclosure. At times, clients with PTSD just want to gain relief; they disclose too much, too soon, without having established trust, an adequate support system, or effective coping strategies. Preparing a woman to respond to trauma-related questions is important. By taking the time with the client to prepare and explain how the screening is done and the potential need to pace the material, the client has more control over the situation. Overall, she should understand the screening process, why the specific questions are important, and that she can choose not to answer or to delay her response. From the outset, counselors need to provide trauma-informed education and guidance.

Culturally Responsive Screening and Assessment

- Foremost, use instruments that have been adapted and tested on women in specific cultural groups and special populations.
- Even though a woman may speak English well, she may have trouble understanding the subtleties of questions on standard assessment tools.
- Acculturation levels can affect screening and assessment results. A single question may need to be replaced with an in-depth discussion with the client or family members to understand substance use from the client's point of view.
- Interviews should be conducted in a client's preferred language by trained staff members or an interpreter from the woman's culture.
- It is important to remember that many instruments have not been tested on women across cultural groups and that caution should be taken in interpreting the results. Counselors need to discuss the limitations of instruments they use with clients.

The most important domains in which to conduct screening when working with women include:

- Substance abuse.
- Pregnancy considerations.

- Immediate risks related to serious intoxication or withdrawal.
- Immediate risks for self-harm, suicide, and violence.
- Past and present mental disorders, including PTSD and other anxiety disorders.
- Past and present history of violence and trauma, including sexual victimization and interpersonal violence.
- Health screenings, including HIV/AIDS, hepatitis, tuberculosis, and sexually transmitted diseases.

Assessment is only as good as the ability to follow through with recommendations

For detailed information on screening and assessment tools that can address each of these domains, see pages 60 through 81 in the complete TIP.

AT-RISK SCREENING FOR DRUG AND ALCOHOL USE DURING PREGNANCY

- In screening women who are pregnant, face-to-face screening interviews have not always been successful in detecting alcohol and drug use.
- Self-administered tools may be more likely to elicit honest answers; this is especially true regarding questions related to drug and alcohol use during pregnancy.
- Although questions regarding past alcohol and drug use or problems associated with self, partner, and parents will help identify pregnant women who need further assessment, counselors should not underestimate the importance of inquiring about previous nicotine use to identify women who are at risk for substance abuse during pregnancy.
- There are other factors that are associated with at-risk substance abuse among women who are pregnant, including moderate to severe depression, living alone or with young children, and living with someone who uses alcohol or drugs.

Note to Clinicians

- Because timely treatment for HIV/AIDS can virtually eliminate the chance of a pregnant woman passing the infection to her fetus, all women with substance use histories should have an HIV/AIDS evaluation at the first sign of any possible pregnancy.
- Methadone maintenance treatment has been recommended as the only treatment for the management of opioid dependence during pregnancy because, when methadone is provided within a treatment setting that includes comprehensive care, obstetric and fetal complications (including neonatal morbidity and mortality) can be reduced.
- Counselors should be sensitive to female clients who are pregnant and help them manage the additional stresses, demands, and guilt that pregnancy can cause in a woman already struggling with a substance use disorder.

TREATMENT ENGAGEMENT, RETENTION, AND PLANNING

Barriers to Treatment Engagement

Women have identified multiple factors as barriers to entering treatment, to engaging and continuing with treatment services across the continuum of care, and in maintaining connections with community services and mutual-help groups that support long-term recovery. At the outset, barriers may exist on several levels. Following are some examples of the types of barriers women may encounter.

Intrapersonal (individual factors)

- Anticipation of not being able to use substances to cope with stress, to manage weight, or to deal with symptoms associated with mental disorders, which creates considerable apprehension in making a commitment to treatment
- Feelings of guilt and shame regarding use and behavior associated with use
- Fear of losing custody of children upon admitting the substance problem or seeking treatment
- Difficulties in accessing treatment, securing appropriate services, and coordinating medical and substance abuse treatment needs

Interpersonal (relational issues)

- Women are usually the primary caregivers of children as well as of other family members; they are often unable or not encouraged to enter and remain in treatment.
- Women are particularly vulnerable to losing their partner upon entering treatment.

Structural (program characteristics)

- Few treatment facilities offer groups or programs for pregnant or postpartum women.
- Few residential programs allow mothers to have their children with them, and outpatient programs often do not provide services for children or child care.
- Few programs can simultaneously combine the necessary prenatal care with substance abuse treatment and services for older children.
- Women may have to travel with their children and use public transportation to reach treatment agencies; this can be a hindrance for women in rural areas and for those who have limited income.

Sociocultural

- Women are more likely to gain awareness of substance abuse treatment and to initiate contact with treatment providers if outreach services are implemented.

- Women worry about being viewed as irresponsible or neglectful “bad mothers” if they admit to substance abuse or dependence; this fear can interfere with help-seeking behavior.
- Women in some cultural groups experience more negative attitudes toward their substance use in general and may have more difficulty engaging in help-seeking behavior and treatment services based on gender roles and expectations.

Systemic (larger systems, policies, and laws)

- Many women in need of treatment are involved in multiple social service systems; services may be fragmented, requiring a woman to negotiate a maze of service agencies to obtain assistance for housing, transportation, child care, substance abuse treatment, vocational training, education, and medical care.
- In entering treatment, women sometimes risk losing public assistance.
- Women who have substance use disorders often fear legal consequences.

Treatment Engagement: Three Core Strategies

The following strategies are particularly successful when working with women.

Strategy 1: Provide outreach services

- Identify a woman's most urgent concerns and address those first, until she is ready to take on other issues.
- Programs that address domestic violence, HIV/AIDS, or crisis intervention can be a vital conduit for helping women take the first step in connecting to substance abuse services.
- Empathize with her fears and resistances while helping her follow through on commitment.
- Help women negotiate the human service system, particularly when the decision to seek treatment is stymied by the lack of adequate, appropriate, or accessible programs.

The barriers that exist before treatment are often the same obstacles that interfere with successfully completing treatment or maintaining abstinence.

Strategy 2: Conduct pretreatment intervention groups

- Prevent more significant alcohol- and drug-related consequences through early identification and intervention.
- Provide personalized or structured feedback to clients about their alcohol and drug use.
- Offer information about available treatment services and treatment processes.

- Use strategies that enhance motivation, decrease alcohol and drug use, and address certain psychosocial barriers.

Strategy 3: Offer comprehensive case management

- Bridge the gap between services and agencies via comprehensive case management.
- Match services to the client's needs rather than forcing the client to fit into the specific services offered by an agency.
- Serve several functions and provide an array of services for the client, including outreach, needs assessment, planning, resource identification, service linkages, monitoring and ongoing assessment, and client advocacy.
- Know that women assigned to intensive case management have significantly higher levels of substance abuse treatment initiation, engagement, and retention; high alcohol and drug abstinence rates; and longer lengths of abstinence. They also tend to access a greater variety of services.

For a complete list of services needed in women's substance abuse treatment, see Figure 5-3 on page 93 of the complete TIP.

Treatment Retention

Women who are in treatment for substance use disorders are more likely to benefit from:

- Supportive therapies rather than other types of therapeutic approaches.
- A therapist's warmth, empathy, ability to stay connected during treatment crises, and skillful management of countertransference during therapy.
- A treatment environment that is supportive, safe, and nurturing.
- A therapeutic relationship of mutual respect, empathy, and compassion.
- Recognition that for parents, especially women, children's safety often is a chief concern and a principal barrier to treatment engagement and retention. Even if women do not have custody of their children, they often are the ones who continue to care for them.
- Less aggressive treatment approaches based on awareness, understanding, and trust.
- Therapeutic styles focused on the treatment goals that are important to the client (this may mean addressing issues of food, housing, or transportation first).

The type of confrontation used in traditional programs tends to be ineffective for women unless a trusting therapeutic relationship has been developed.

- Therapeutic styles that facilitate the client's awareness of the differences in the way her life is now and the way she wants it to be.
- A view of treatment as a collaboration of equal partners—the therapist is the expert on what has helped other people, and the client is the expert on what will work for herself.
- Women-only groups that specifically provide more gender-responsive services.
- Access to various services in one location.
- Greater intensive care (specifically residential treatment).
- Treatment services that include individual counseling.
- The ability to keep their children with them while in treatment.
- Relationships or connections that are maintained throughout treatment and during step-down transitions from more to less intensive treatment.
- A counselor's confidence in their progress.

Although many women find women-only groups beneficial, some may express hostility toward other women in such groups or treatment programs; they may see other women as a threat to their relationships and engage in competitive behavior in the group process, or they may project their internalized negative stereotypes of women onto other group members.

Note to Clinicians

Women appear more likely to attend continuing care, yet they often express feelings of disconnection with the new treatment provider and struggle to manage the added demands and expectations of child care while attending less intensive treatment.

Women are more likely to engage in continuing care if the primary treatment they received involved specialized programming for women.

Treatment Planning Considerations

Involving intimate partners in treatment

In deciding whether or not to involve a woman's partner in treatment, primary consideration should be given to her safety and to the partner's willingness to participate in treatment. If the client does not feel safe involving her partner, the emphasis should change to safety planning.

The following important issues should also be assessed to determine participation and level of treatment involvement and to establish an appropriate treatment plan:

- Is there a history of violence in the relationship?
- Is there a history of substance use in the relationship?

- How influential has this partner been regarding the client's continued drug and alcohol use?
- Does the partner see the client's alcohol and/or drug use as a problem needing treatment?
- How often are substances used during sexual intimacy or other activities with each other?
- Has the client left prior treatment experiences prematurely due to this relationship?
- What is the partner's attitude toward alcohol and drug use?
- Are there potential barriers that limit physical attendance, such as distance from program, transportation, work schedule, financial resources, childcare responsibilities, or similar concerns?
- Are there any known mental health issues with the partner or client that have affected or will affect the relationship?
- Has the partner ever threatened to leave, withdraw financial support, or dispute the custody of the children?
- Is there a current commitment to maintaining the relationship?

Parenting and relationship-building skills development: Psychoeducational and clinical factors

Combining behavioral training with attachment-based parenting interventions appears to be beneficial. This strengths-based relational approach to parenting assumes maternal assets already exist that can be identified and built on and that the emotional quality of the parent-child relationship

is equally important in improving that relationship and the psychological adjustment of the child. Topics for parenting skills and relationship building include:

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

Addressing co-occurring disorders

- Provide women who have co-occurring disorders with comprehensive coordinated services using an integrated treatment model.

- Screen and assess for trauma as a standard practice for women in treatment for substance use disorders.
- View services as long term, suggesting a range of continuing care services and peer support, such as 12-Step programs, group therapy, or women's support groups.
- Attend to a client's reaction to medication and compliance, particularly when she is treated for mental illness.

Note to Clinicians

Often, clinicians fear that addressing trauma-related issues is counterproductive and may produce deleterious effects on women in substance abuse treatment. However, data support the safety of integrated, trauma-focused interventions for women in substance abuse treatment programs and show no differences in adverse mental disorder and substance abuse symptoms or events compared with standard care. Although the selection of services and the planning for how to deliver trauma-informed services is important in maintaining integrity of care for clients, integrated, trauma-focused interventions are not only a viable option, but also an essential component of treatment for women with substance use disorders.

Women with substance use and eating disorders

Severe binge eating is consistently associated with alcohol consumption, and dieting and purging are associated with stimulant and sleeping pills/sedative use. Approximately 17 percent of women seeking treatment for either anorexia nervosa or bulimia nervosa have a lifetime drug use disorder.

Overall, research indicates that substance abuse is accompanied more often by bulimia and bulimic behaviors than by anorexia. Nearly one third of women with a history of bulimia also have a history of alcohol abuse, and 13 percent have a history of alcohol dependence.

Attitudes toward dieting among young women may be related to increased susceptibility to alcohol and drug use. This is both a health issue and a relapse risk, because some women may use cocaine or amphetamines (or both) to manage their weight. Additionally, the tendency to overeat affects many women in early recovery. Compulsive or binge eating bears a similarity to abuse of substances other than food and is correlated with depression, thoughts of suicide, and childhood sexual abuse. Women engaging in binge eating sometimes use food as a substitute for alcohol and drugs; others may overeat to compensate for the stress they experience in early abstinence.

Elements of the eating disorder may take the place of relapsing to the drug of choice.

Advice to Clinicians: Women With Eating Disorders

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

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

PREDICTORS OF RELAPSE AND REACTION TO RELAPSE AMONG WOMEN

Relapse Risks Unique to Women

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

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

Be aware that weight gain during recovery can be a major concern and a relapse risk factor for women.

Women's Reactions to Relapse

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

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

TREATMENT CONSIDERATIONS FOR DIVERSE POPULATIONS

Hispanic/Latina Women

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

African American Women

- Incorporate a strengths-based approach rather than relying on a traditional deficit model.
- Use an Afrocentric perspective, when appropriate and welcomed, to provide a framework for recovery.
- Provide trauma-informed services that encompass the impact of cumulative stress from historical trauma, including the experience of prejudice and discrimination, to specific trauma.
- Involve family members and community to build a network of safety and support.

- Recognize the relevance of spirituality for the client and encourage involvement, when appropriate, to enhance or secure recovery.

Asian American and Pacific American Women

- Address the importance of ethnic heritage and assess the level of acculturation at the beginning of treatment to avoid making assumptions regarding cultural values, family structure, gender roles, and styles of communication.
- Incorporate drug and alcohol education to reduce the stigma attached to substance abuse and dependence.
- Approach treatment from the vantage point of promoting overall health rather than focusing solely on substance abuse; include a holistic connection between body, mind, and spirit. Reframe the presenting problem by emphasizing the positive aspects of change.
- Provide a nurturing environment that does not encourage cultural and gender-related tendencies toward self-blame.
- Develop trust and build a therapeutic alliance to help decrease internalized feelings of guilt and shame.
- Honor the importance of family as the focal point, and acknowledge that maintaining family honor, obligations, and responsibilities is central to women.

- Focus on problem-solving, goal-oriented, and symptom-reduction strategies to circumvent the likely shame associated with delving into past alcohol or drug use behavior.
- Explore the history of trauma and the potential for posttraumatic stress. Many older immigrant Asian American women have been exposed to losses, torture, and other types of war-related trauma.

Native American Women

- Assess for a history of traumatic events, including sexual and physical abuse, and a diagnosis of PTSD.
- Provide trauma-informed services that encompass the impact of cumulative stress from historical trauma to specific trauma.
- Recognize that the role of “helper” may extend beyond substance abuse counseling to seeking advice for other health concerns, for other family members, or for other life circumstances or stressors.
- Acknowledge the importance of family history and extended family members, and, as appropriate, involve family members during treatment.
- Explore beliefs regarding healing and knowledge of cultural practices. Do not assume that a Native American woman follows traditional practices.

- Understand and acknowledge the specific Tribe’s cultural values, beliefs, and practices, including customs, habits, gender roles, rituals, and communication styles.

Lesbian and Bisexual Women

- Explore coping style and enhance coping skills needed to manage stress associated with self-disclosure and the “coming out” process, to deal with attitudes from others regarding sexual orientation, and to address feelings of alienation from family members who reject the client’s sexual orientation.
- In addition to appropriate family members, consider friends as a vital component of treatment and support structure. Lesbians generally receive greater support from friends than from family. Social support from family and friends will likely enhance psychological well-being.
- Assess for interpersonal violence. Rates of partner violence or abuse among lesbian women are similar to those among heterosexual women, and partner abuse often is accompanied by alcohol use. Assess for history of traumatic events, including sexual and physical abuse and a diagnosis of PTSD.

Older Women

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

Women in Rural Areas

- Screen for co-occurring disorders, and refer as needed.
- Obtain a history of traumatic events, including sexual abuse.

- Incorporate screening procedures to aid in appropriate referral to other health and social services.
- Explore potential reluctance in seeking help outside of the client's immediate community.
- Assess for a history of interpersonal violence, and recognize that rural women have often reported learning that violence toward women is acceptable.
- Explore beliefs and attitudes toward alcohol and drug use.

TREATMENT OUTCOMES— DID YOU KNOW?

- Gender is not a significant predictor of treatment outcome. Once in treatment, women are as likely as men to complete treatment and have good treatment outcomes.
- One year after discharge from treatment, women have abstinence rates and overall quality of life similar to those seen in men.
- For women with posttraumatic stress reactions, literature supports the relationship between the receipt of integrated trauma-informed treatment services and positive treatment outcomes.
- For women, participation in 12-Step programs and involvement in social networks that support recovery are important ingredients in maintaining abstinence for 5 or more years.
- There appears to be a stronger association between treatment participation and posttreatment outcomes among women.
- Treatment completion and length of stay in residential treatment are important factors in establishing positive posttreatment outcomes among women.
- In residential treatment for pregnant and parenting women and their children, longer length of stay is associated with increased abstinence, improved employment and income, decreased

arrests and depressive symptoms, and more positive attitudes toward parenting.

- Relapse rates in women who complete treatment for substance use disorders are not significantly different from those seen in men.
- Women show greater increases than men in employment, recovery-oriented social support systems, and participation in mutual-help groups.

Ordering Information

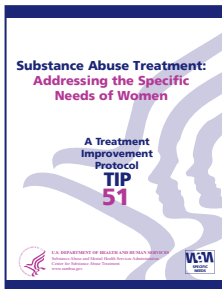
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