3.5 Issues Related to Treatment of Alcohol and Other Drug Use in Women

This section describes a number of issues related to the treatment of substance abuse in women. It is not intended to address all issues specifically related to women, but rather to highlight those that are generally perceived as the most critical in implementing substance abuse treatment. The strategies that are recommended for addressing these issues are described throughout the remaining chapters of the manual. To the extent that epidemiologic data are available, they have been presented in Chapter 2.

3.5.1 Relationships and Other Gender Issues

A number of experts in the field of women and addiction have noted that women who abuse alcohol and other drugs tend to have relationships that are characterized by unhealthy dependencies and poor communication skills.[26] Because many recovering women have had few positive relationships, they have few models for developing healthy relationships.

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Covington and Surrey have described a useful model for understanding the importance of relationships in women's lives and in the process of substance abuse and recovery. Termed the "relational model," it emphasizes the centrality of relationships for women, considers their role as caretakers, addresses the issue of co-dependency, and focuses on strengths in women's relationships as a means of recovery. Covington and others have found the model to be helpful in "conceptualizing the contexts and meanings of substance abuse in women's lives and particularly helpful in suggesting new treatment models."[27]

Following are examples of unresolved relationship issues and strategies to address these issues; most have been derived from Advances in

Alcoholism Treatment Services for Women:[28]

- Issues between mother and children
  - Invite mothers and children to participate in educational activities.
  - Involve mothers and children in individual, group, and family therapy sessions.
- Issues of intimacy and friendship (often confused with issues of sexuality)
  - Hold therapy groups and workshop sessions in which educational material and experiential exercises are used to help clients understand the difference between intimacy and sexuality.
  - Encourage nonsexual friendships between women and men.
  - Review patterns of relationships through individual and group therapy.
  - Explore personal needs and wants in the following areas: economic, sensual/sexual, emotional, social, intellectual, and spiritual.
  - In some circumstances, recommend periods of celibacy.
- Issues of mistrust and competitiveness with other women
  - Involve the clients in women-only therapy groups and include discussions designed to empower women to trust themselves first, as a basis for developing trust in others.
  - Educate clients about women's history, including socialization of women's relationships with one another.
- Issues of self-development, independence, and interdependence.

— Use group living situations to refocus attention on individual needs.

— Use visual aids to enable the client to see and analyze various aspects of her life's activities (the "circle overlap").

The concept of "codependency" was developed to describe the complex interrelationships that can occur with the underresponsibility/ overresponsibility dynamics that develop in many relationships marked by alcohol and other drug use.[29] Until recently, most substance abuse treatment programs have addressed primarily the needs of men. Therefore, to the extent that codependency issues have been confronted, this has been done primarily with male clients vis-a-vis their female partners.

There is a significant lack of clarity in the definition of the terms "enabling" and "codependency," with viewpoints expressed in the literature deriving from the particular author's vantage point. Sociopolitical issues concerning gender relationships and relative positions in society are often not addressed in the substance abuse treatment literature. Rather, there seems to be a focus on the "pathology" of codependency, which implies (and can encourage) guilt on the part of the woman.[30] As Beattie has described in her books on codependency, the client needs to learn that she can continue to care about people, but that she has choices. She is responsible for her behavior and the consequences of that behavior, including unhealthy codependency.[31] Identifying her codependent behaviors and those with whom she is involved in these behaviors is an important step in recovery from codependent relationships. These behaviors include, for example, controlling relationships, repressing feelings, self-neglect, and not setting boundaries.[32]

Treatment program staff, clients, and their partners need to address the imbalances of responsibility and gender patterns found in families and personal relationships that are so often destructive to both women and men.

When a woman has gained a degree of stability in treatment, it is often helpful for her to participate in both women-only and mixed gender codependency groups for support in recovering from unhealthy codependent behavior characterized by past relationships. Treatment programs should ensure that clients who are codependent have access to groups (either on-site or through referral) that address issues of codependency, including, for example, Codependents Anonymous (CoDA) and Families Anonymous.

An example of a client who has relationship problems along with treatment strategies to address them is shown on the following page.

Example of Presenting Problem

Relationships

After several months in an outpatient program in which she is being treated for heroin addiction, a 35-year-old woman with a history of relapse expresses to a counselor discomfort with both physical and emotional aspects of sexual relationships. After some discussion during the counseling session, it is revealed that the woman's parents were both alcoholics. Her father also used heroin for several years and had sexually abused her. Although the woman had several brothers, she was invariably the child who cared for the parents. Her father died when she was 18, but she cared for her mother until she died, at which time the client was 33.

Alternative Strategies

While treating the woman's substance abuse problem itself, staff should consider the following to address the relationship issues she faces:

- Assess treatment history, particularly her experience in methadone programs (as with heroin, methadone can reduce libido; given the woman's personal sexual history, this is important information).
- During individual counseling, the woman should be assisted in understanding unresolved issues with her parents and with her brothers, whom she feels did not share responsibility for care of their parents.
- Arrange for group counseling with other women in recovery who are adult children of alcoholics and/or heroin addicts.
- During individual and group counseling, explore issues of intimacy and friendship and those of self-development, independence, and interdependence. Encourage nonsexual friendships with women and men.
- Arrange for assertiveness training conducted by trained staff or through referral to appropriate services in the community.
- In discharge planning, either conduct directly or arrange for post-treatment psychological assessment and evaluation of client outcome in terms of psychosocial measures and for continuing psychological counseling, as necessary.

3.5.2 Issues of Sexuality

Women in treatment for substance abuse problems often must not only address issues of sexuality faced by other women, but a myriad of other issues as well. As noted in Chapter 2, women who have abused alcohol and other drugs have many physiological repercussions that may affect their sexual functioning (e.g., hormonal changes, liver damage). Covington has found that women recovering from alcohol abuse were much less likely to report satisfaction with their sexual functioning than were nonalcoholic women (55 percent versus 85 percent, respectively).[33] She also has identified related psychological repercussions, including diminished self-worth, an avoidance of relationships, and possible depression related to sexual functioning.[34] Comparable data relating sexual functioning to the use of other drugs is not readily available.

Staff members must be knowledgeable about and comfortable with discussing sexuality and intimacy issues with women.

Many women go through treatment without addressing their sexuality and intimacy issues, in part because few counselors are prepared to deal effectively with women's sexual concerns. Because alcohol and other drug use and sexuality can be entwined, staff members must be knowledgeable about and comfortable with discussing sexuality and intimacy issues with women in individual and women-only group sessions. If staff members are unable or unwilling to talk openly about these issues, a woman's fears and concerns will only be exacerbated, and the possibility of a healthy recovery may be limited. Staff members also must be comfortable talking with women about incest, rape, or sexual abuse issues since these are often the core problems underlying sexual dysfunction in women who abuse substances.

An additional issue to be addressed is the fact that, as a recently published CSAT report, State Methadone Maintenance Guidelines, states: "because addicted women rarely have highly paid roles in the drug-dealing network, prostitution is common and also negatively influences intimate

relationships."[35] Sexual relationships with injecting drug users also place the woman at-risk for AIDS/HIV, as is discussed in Chapter 2. Both of these are issues that can be addressed through individual and group counseling focusing on intimate relationships; however, the issue of prostitution is one related to economic status and self-sufficiency as well.

The following types of strategies are useful to address sexuality issues:

- Conduct workshops and use educational materials on the relationship between substance abuse and sexuality, sexual functioning, and incest and other sexual abuse to show women that their experience is not unique and that it is possible to heal and develop a more satisfying life.

- Offer group counseling for women only, so that sexual problems and sexuality (including sexual communication styles and the dynamics of sex and power) may be comfortably and openly discussed in language familiar to clients.

- Encourage women to discuss their sexual problems, and let them know that some sexual problems (for example, physical problems related to drug use such as lack of sexual desire among heroin-addicted women) may resolve themselves over time with continued abstinence from drugs. Other problems that result from underlying experiences such as incest or suppressing sexual feelings as a result of prostitution, will require clients to explore and work out their feelings about those experiences.

- Refer women who are sexually dysfunctional for medical and psychological assessment to determine the organic and or psychological bases for the dysfunction. Treatment should follow this assessment. For example, the client who has been sexually abused should be referred for psychological counseling or sex therapy to a therapist who can address her needs. Ensure that such counseling is culturally sensitive and that it addresses a women's spiritual needs.

- Provide specific supportive treatment for the client who has been a prostitute and/or who has exchanged sex for drugs. Help her explore her lifestyle and, through internal and external community resources, give her the tools to change her lifestyle.

- Hold discussions to inform women of their legal rights, and educate female clients about what constitutes violence and abuse against women including physical battering, forms of verbal abuse, violation of physical space boundaries, forced sex, unwanted touching, or a partner's flaunting of affairs. Raise consciousness about what constitutes abuse, so that women become empowered to stand up for their rights and educate their children about their rights.

3.5.3 Women, Violence, and Substance Abuse

The first comprehensive national survey of the health of American women, conducted in 1993, found that thirty percent of women (an estimated 30 million women) suffered some type of abuse as a child. Ten percent reported having been sexually abused, 13 percent reported having been physically abused, 27 percent reported having been emotionally or verbally abused.[36] This same study found that in the year prior to the survey, seven percent of women reported being physically abused and 37 percent reported being emotionally or verbally abused by their partner.[37] Two percent of respondents —an estimated 1.9 million women —reported having been raped in the previous five years.[38]

The prevalence of violence against women in the general population, while of startling proportions, is overshadowed by the reported prevalence among women who enter substance abuse treatment programs.

The prevalence of violence against women in the general population, while of startling proportions, is overshadowed by the reported prevalence among women who enter substance abuse treatment programs. In her review of published research on sexuality and drinking behavior, Wilsnack found that between 41 percent and 74 percent of women in treatment for alcohol and other drugs reported being childhood or adult victims of sexual abuse, including incest.[39] A number of researchers (e.g, Bergman, et al[40] and Covington[41]) have found significantly higher proportions of a history of

sexual and/or physical abuse among women in treatment than among comparison groups of women. In some cases, at least half of the women entering treatment have been battered or raped and most have been emotionally abused. There is little data available on women's exposure to violence in their environment (e.g., murder, armed robbery, or assault), which has also been linked with post-traumatic stress disorder (PTSD) and which can contribute to the woman's vulnerability to seeking drug-induced means of removing herself from her unsafe and insecure environment.

The wide range of findings with respect to history of sexual abuse among women in treatment is in part due to the difference in definitions of abuse used by the researchers. For example, in describing a range of 30-80 percent in reported incest among women in treatment for heroin addiction in studies published over several decades, Worth[42] noted the inconsistent definitions of incest used by the authors of the published studies.

Most women who are victims of partner violence do not discuss the incidents with anyone and most who are victims of any type of crime and who required medical treatment are not referred to any type of support service by a treatment provider.[43] Both as a result of the violence itself and the inadequacy of support systems, the victim endures physical and psychological impacts that are well documented. It is also important to acknowledge that racial, ethical, and cultural differences do exist in patterns, interrelationships, and outcomes associated with violence. These factors have not been systematically examined.

The psychological impact of violence includes mood disorders (e.g., depression), anxiety disorders (e.g., PTSD), and low self-esteem. A recently-published CSAT TIP entitled "Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse," specifically addressed the relationship between sexual abuse (including incest) and alcohol and other drug use:

> Clinicians note that long-term responses to childhood and adult sexual abuse often include symptoms associated with PTSD and other psychiatric problems, including an increased risk for [alcohol and other drug] AOD disorders.[44]

For many women who have been victims of personal violence, use of alcohol and other drugs can become a coping mechanism.

Paone and others have noted that, for many women who have been victims of personal violence, use of alcohol and other drugs can become a coping mechanism, whereby they self-medicate to alleviate feelings of anxiety, guilt, fear, and anger that result from the violence.[45]

Because the partner of the woman in treatment is often a user of alcohol or other drugs, the link between such use and violence is also an important consideration for treatment programs, particularly those which have as an objective family reunification. It is important to note that alcohol abuse by lesbians has been identified as both a cause and effect factor related to violence among partners.[46] Alcohol consumption has been linked to fight-related homicide, assault, rape, and spouse and child abuse, all of which the woman may have experienced just prior to entering treatment and to which she may be vulnerable following treatment. For example, in a national study of homicide perpetrators, 36% were under the influence of alcohol alone at the time of the crime and an additional 13% were under the influence of alcohol in combination with another drug.[47] A subsidiary issue is the fact that, increasingly, use of alcohol by the victim is seen as related to increased vulnerability to victimization. However, this should in no way be interpreted as suggesting that, for example in the case of spouse abuse, this vulnerability is "an excuse for [or] a direct cause of" the crime.[48] Use of crack cocaine has also been associated with violent behavior, but minimal data are available specifically with regard to its impact on personal violence directed at women, or conversely, personal violence committed by crack cocaine-addicted women.

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