GENDER DIFFERENCES AND IMPACTS ON ADDICTION TREATMENT: SPECIAL CONSIDERATIONS FOR WORKING WITH FEMALE CLIENTS

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A Capstone Project submitted in partial fulfillment of the

requirements for the Master of Science Degree in

Counselor Education at

Winona State University

Academic Semester: Spring 2014

Winona State University

College of Education

Counselor Education Department

CERTIFICATE OF APPROVAL

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CAPSTONE PROJECT

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Project Title

Gender Differences and Impact on Addictions Treatment: Special consideration for working with Female Clients

This is to certify that the Capstone Project of

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Has been approved by the faculty advisor and the CE 695 – Capstone Project

Course Instructor in partial fulfillment of the requirements for the

Master of Science Degree in

Counselor Education

Abstract

Special considerations when working with women with substance use disorders were assessed in comparison to male counterparts. Topics included gender differences relating to physiological, psychological and socio-cultural spheres. Treatment considerations related to trauma sensitivity, marginalization and stigma were addressed. Special considerations relating to female racial minority populations were evaluated and explored. Research included a comprehensive literature review of peer-reviewed journal articles, research studies and government report findings covering multiple disciplines: counseling, neuropsychology, medical, criminal justice and social work. Findings of this research revealed significant diversity and complexity within the American population of females struggling with chemical addiction. Due to this complexity, working with females in addictions treatment can be more challenging than working with males and frequently requires multiple levels of treatment. The findings of this paper encourage counselors, even those not directly working in addictions, to become more aware of these special considerations when working with female clients.

Contents

Introduction

In 2012, an estimated 1.4 million individuals in the United States entered treatment for Substance Use Disorders (SUDs), including both substance abuse and substance dependence disorders (SAMHSA, 2013). This may seem like a large number and it is; however, this is only 7.7% of the estimated American population living with SUDs (SAMHSA, 2013). It becomes unmistakable that addictions are a major problem in the United States and that there are many barriers regarding the accessibility of appropriate treatment options (SAMHSA, 2009). Women remain a minority segment within this population and within treatment programs because men are more likely to be addicts than women (Harvard Medical School, 2010). In 2008 the US National Survey on Drug Use and Health reported that 11.5% of men and 6.5% of women ages 12 and older had SUDs (Harvard Medical School, 2010). In part, because of this difference, treatment programs were traditionally designed by men and for men, and have not been perfectly sensitive to the different complications and complexities that women in treatment are facing in their recovery (Briggs & Pepperell, 2009). The most common treatment modalities in the United States are based on the Alcoholics or Narcotics Anonymous 12 step principles which were created by two white men in 1935 (Stevens & Smith, 2005). Though most addictions professionals would agree they are important and typically successful in treatment, this model and system have their limitations when working with women (Krestan, 2000). Women are physiologically, psychologically, and socio-culturally different than men and require special accommodations in addictions treatment (Briggs & Pepperell, 2009; SAMHSA, 2009).

Review of Literature

The past ten to fifteen years have yielded a large quantity of cross-disciple research dedicated to gender differences in regards to addiction (SAMHSA, 2011). Medical professionals have broadened their focus away from basic biology, and are now applying a systems perspective concentrating on public health and prevention (Harvard Medical School, 2010). This broadened understanding of addictions in women has pulled information from other fields including: counseling, neuropsychology, social work, and criminal justice systems (Krestan, 2000; Laux, et al., 2008). Addiction counselors have the important role of informing other disciplines about treatment considerations and the broad-sweeping effects of trauma in women while remaining abreast of modern research from other fields of study (Lester, 2000; Matheson, 2008). Research has identified that women are physiologically, psychologically, culturally, and relationally different from men in regards to the addiction process, treatment, and maintenance of recovery (SAMHSA, 2009; Bromberg, Backnam, Krow, & Frankel, 2010; Mack, Jones, & Paulozzi, 2013).

Physiological Gender Differences

Women have some significant physiological differences from men which includes making them more susceptible to addictive substances; these include body structure, metabolic mechanisms, and hormone effects, (Inaba & Cohen, 2004; Gunberg, 1998). One consideration is that the average woman is 25-40% smaller than the average size man, and this smaller body concentrates alcohol and other drugs, making them more potent (SAMHSA, 2009). Additionally, women have a lower water content and higher body fat level; the extra fat stores and holds substances longer than water, increasing the length of intoxication (Harvard Medical School,

2010). Even women of healthy weight have high body fat concentrations in both breast development and the fat surrounding abdominal organs (Harvard Medical School, 2010). Women are physically built differently than men in regards to their mass and body fat concentrations, and these differences directly impact the effects drugs and alcohol have on their bodies (SAMSHA, 2009).

"Although the differences in the way women and men metabolize alcohol have been studied in some depth, research on differences in metabolism of illicit drugs is limited (SAMHSA, 2009, p. 37). Generally speaking, women have slower and less effective metabolic systems in comparison to men, namely lower production rates of enzymes responsible for breaking down alcohol and other drugs (Inaba & Cohen, 2004). Women's pancreases make a significantly lower level of the enzyme alcohol dehydrogenase, which breaks down alcohol in the stomach meaning more alcohol is absorbed into the bloodstream (Roberts, 1998; Harvard Medical School, 2010). As a result, more of the alcohol/drug is delivered to vital organs including: the brain, heart, liver, and reproductive structures (Inaba & Cohen, 2004). "One researcher concluded that women's lack of a functional gastric protective barrier means that 'for an alcoholic woman to drink alcohol is the same as taking the alcohol directly into a vein'" (SAMHSA, 2009, p. 40). Additionally, women have a lower level of the liver enzyme aldehyde dehydrogena, which is needed to break down alcohol, further delaying alcohol metabolism and keeping alcohol in the blood longer (Harvard Medical School, 2010; Stevens & Smith, 2005). Similar findings have been found regarding metabolization of other drugs which include heroin, cocaine, and nicotine (SAMHSA, 2009). In short, although individuals vary, as a group, women's metabolic systems are less effective than their male counterparts in the processing of alcohol and other drugs (SAMSHA, 2009).

Women have long been labeled as over-emotional and irrational because of the effects of hormonal cycles (Carpenter, 2012). However, time and again, research has backed that women do experience significant changes across multiple body systems as a result of hormonal fluctuations, and these have significant impacts on the addiction process (Briggs & Pepperell, 2009; Grunberg, 1998, SAMHSA, 2009). Though more research needs to be done, there appears to be a link between a woman's estrus cycle and addiction cravings (SAMHSA, 2009; Roberts, 1998). Robert's (1998) study demonstrated that rats had twice the drug-seeking dedication towards cocaine during estrus. Preliminary research has indicated that there are certain points of a women's menstrual cycle during which it is easier to quit smoking; "one theory is that the increase of estrogen levels during the follicular phase decreases anxiety and improves mood, helping a woman cope better with the challenges of smoking cessation" (Harvard Medical School, 2010, p.3). Briggs & Pepperell (2009) cite that women experience a higher level of euphoria from cocaine before ovulation when estrogen levels are high. Hormone fluctuations, particularly of cortisol, have been linked to weight gain when quitting stimulant drugs such as nicotine, cocaine, and amphetamines (Brggs & Pepperell, 2009; SAMHSA, 2011). This can become a significant barrier for women abstaining especially when eight out of ten American women are not happy with their body image and have strong feelings against gaining weight (SAMHSA, 2009 &2007). Unlike men, women's bodies experience monthly and lifelong cycles of hormone production which have important impacts on how drugs and alcohol impact them (SAMSHA, 2009).

For numerous biological reasons, including body structure, metabolic processes, and hormonal cycles, women are more susceptible to negative health consequences of substance abuse (SAMHSA, 2009). At the root of all addiction is a chemical-biological reaction; because women are designed differently than men their bodies handle chemicals differently (Mack, Jones, et al., 2013; Stevens & Smith, 2005). Not only do physiological gender differences impact

intoxication, they significantly increase the likelihood of physical health problems, exacerbate psychological conditions, and intensify the addiction process (SAMHSA, 2007 & 2009).

Multiple studies have indicated that even though female addicts use, on average, one third the quantity of alcohol or drugs as their male counterparts, they suffer serious health conditions faster and more frequently (Inaba & Cohen, 2004; SAMSHA, 2011; Roberts, 1998). Even with using smaller amounts of alcohol, women "have a 50-100% higher death rate than male alcoholics" (Inana & Cohen, 2004, p. 212). "Compared with men, women become more cognitively impaired by alcohol and are more susceptible to alcohol-related organ damage. Women develop damage at lower levels of consumption over a shorter period of time" (SAMHSA, 2009, p. 40). Male addicts are also likely to develop brain damage affecting reasoning, perception, information processing and mood regulation, but women are at higher risk for developing these complications (SAMHSA, 2009). Additionally, in part because of high blood alcohol levels after drinking the same quantity, women are more likely than men to experience various types of liver failure and eventual death (SAMHSA, 2007 & 2009). Women who are heavy drinkers experience infertility at higher rates and are more likely to have pregnancy complications than those who have not drunken heavily (SAMHSA, 2009). Furthermore, "[t]he female heart appears to experience a functional decline at a lower level of lifetime exposure to alcohol than does the male heart" leading to hypertension, cardiac arrest, and death for many women who have been drinking for shorter period than male counterparts (SAMHSA, 2009, p. 41).

Similar findings have been found in cocaine and crack use among women; although both male and female addicts are susceptible to cardiac consequences, women's risks increased with lower lifelong quantities than men's (Inaba & Cohen, 2004). Regarding

other illicit drug use health consequences, more women than men are treated for opiate overdose and "more women have died every year of opiate overdose than motor vehicle accidents since 2007" (Mack, et al., 2013). Female addicts are more likely to have reproductive, digestive, lung, and brain cancers than male addicts, even after using significantly less alcohol or drugs (SAMHSA, 2007 & 2009, Inaba & Cohen, 2004). Like their male counterparts, female alcoholics frequently have poor nutrition and suffer from related complications including vitamin deficiency, pancreatitis, diabetes and bone fragility (SAMHSA, 2009). In conclusion, because of physiological differences, women are significantly more likely to suffer substantial health consequences or death from drug or alcohol use, even while consuming smaller quantities than men (Harvard Medical School, 2010).

Psychological Gender Differences

Some research has indicated that women have stronger emotional and psychological reactions to mood altering chemicals (Roberts, 1998). Drugs and alcohol impact psychological wellbeing in both men and women, but it appears women experience more intense psychological consequences (SAMHSA, 2007; Roberts, 1998; Grunberg, 1998). Central nervous system depressants such as alcohol and benzodiazepines not only depress physiological functions of the lower half of the brain, but also emotions (Inaba & Cohen, 2004). Simply stated, these drugs tend to depress overall mood, especially when used heavily over longer periods of time, and these mood effects tend to be more significant in women than men (Inaba & Cohen, 2004; Roberts, 1998). Central nervous stimulants including cocaine, nicotine and amphetamines tend to stimulate the brain and increase anxiety in addicts, especially in women (Inaba, 2004; Woods, 1998). Beyond biology, drug seeking behaviors and lifestyle also increase feelings of depression, hopelessness and anxiety, which further precipitate a vicious cycle of emotional chaos for female

addicts (Roberts, 1998, Grunberg, 1998, SAMHSA, 2012). Chemical changes happening in the brain during chronic drug use exacerbate pre-existing mental health concerns for women (SAMHSA, 2009).

Women progress from abuse to dependency up to ten times faster than male counterparts, developing tolerance, cravings, withdrawal potential and behavioral patterns (Harvard Medical School, 2010; SAMSHA, 2007, 2011). This accelerated process in women has been well documented and is called "telescoping" (Inaba & Cohen, 2004; Harvard Medical School, 2010). Women tend to seek treatment upon the advice of medical professionals more often than men who are more likely to seek treatment following legal situations and court mandates (SAMHSA, 2007; Laux et al., 2008). Some research has found that women frequently experience more intense pain-based withdrawal symptoms and "often find it harder to quit using addictive substances, and are more susceptible to relapse" than men (Mack et al., 2013; Harvard Medical School, 2010, p. 1). Other research indicated that once in a treatment program, women are as likely to succeed in long-term sobriety as men but may find quitting without treatment more difficult (SAMHSA, 2007; Harvard Medical School, 2010). Research focused on tobacco cessation has found that women are more likely to experience psycho-social effects, "while male smokers are more responsive to the biological effects of nicotine" (Harvard Medical school, 2010). This may support the concept that women react differently to different drugs because women appear more susceptible to physical addiction than men in opiates and alcohol, but not in nicotine or cannabis (Grunberg, 1998; Harvard Medical School, 2010; Mack et al, 2013). This paints a complex and under-studied picture for physiological addiction potential and addiction process differences between men and women, and would indicate that further research in this area is required (SAMHSA, 2009).

Further complicating the addiction process in women is the strong prevalence of co-occurring mental health disorders, included are mood, anxiety, psychotic and trauma-related disorders (SAMHSA, 2009 & 2012). Both women and men in addictions treatment are likely to struggle with mental health concerns, though women have a higher rate of comorbidity as 86% of women in SUDs treatment have co-occurring disorders (Hesselbrock & Hesselbrock, 1993; SAMSHA, 2007 & 2009). "Over five million adults in the United States have a co-occurring substance use disorder and serious psychological distress. "This is one of the most stigmatized and poorly served populations in both addiction and mental health treatment." (Magura, 2008, p. 1904). Treatment for clients, particularly women, with co-occurring disorders can be complex and frustrating as mental health symptoms mask and feed off of and into addiction and intoxication symptoms (Magura, 2008; Briggs & Pepperell, 2009; SAMSHA, 2009).

Women are more likely than men to suffer from depression and bi-polar disorders for a number of reasons, included are exposure to more negative life experiences, stressors, and possibly having a biological predisposition towards these mental health concerns (Briggs & Pepperell, 2009; SAMSHA, 2011). It is advised when working with teenage girls suffering from depression, roughly 15-20% of the general population, to be mindful that they are at higher risk of substance abuse and dependency as they attempt to "self-medicate with drugs or alcohol" (Briggs & Pepperell, 2009, p. 63). Early screening and intervention in teenage girls can prevent crippling addiction later in life; for this reason, SAMSHA (2012) advises both mental health and medical professionals to be versed in both depression and substance abuse screening. Related to depression, in 2012 opiate pain medications "were involved in one in 10 suicides among women" in the United Stated; this is four times higher than the rates for men (Mack et al., 2013, p. 538). It

is difficult to determine what comes first, depression or addiction, and all women are different, however many women who have addictions suffer from both (SAMSHA, 2007 & 2009).

Another gender difference regarding dual-diagnosis treatment is that women tend to seek treatment for anxiety disorder at higher rates than men, and often will seek treatment for this before their substance use (Briggs & Pepperell, 2009; SAMSHA 2007). Unlike men, women more frequently experience anxiety before addiction and begin substance abuse as a means of self-medication; whereas men may first abuse drugs/alcohol and later have anxiety as a result of negative consequences from substance abuse (Briggs & Pepperell, 2009; Hesselbrock & Hesselbrock, 1993). Multiple studies have found that comorbid anxiety disorders in women "can significantly increase the risk for relapse following treatment" (Kushner, 2006, p. 697). Studies have also found that because of the high comorbidity rates with addiction and anxiety, particularly in women, traditional group formatted treatment options can exacerbate social anxiety and eating disorder symptoms if they are left unaddressed (Briggs & Pepperell, 2009; Kushner, 2006). This becomes a difficult treatment situation because most counselors working in addictions are not dual-licensed to assess or treat mental health conditions, such as anxiety, and require further referral to address these concerns (Stevens & Smith, 2005).

One more gender difference relating to dual-diagnosis treatment is that over 90% of all reported eating disorder cases are found in women (SAMSHA, 2013). Many women will either use drugs such as amphetamines to accelerate weight loss or will experience binge eating during marijuana or alcohol intoxication (Briggs & Pepperell, 2009; SAMSHA, 2012). Amphetamines and other stimulants, such as cocaine and caffeine, are well known for their appetite suppression properties, which are very obvious when looking at the leading ingredient in most diet supplements (Inaba & Cohen, 2004). Hence, if a woman is dually-diagnosed with a stimulant

abuse disorder and a restrictive type of eating disorder, she may be reluctant to quit use if her eating disorder is not being addressed because the drug is helping to suppress her appetite (SAMSHA, 2012). Conversely, marijuana is strongly connected with binge eating or craving high calorie foods during intoxication, which could feed binge eating disorder or bulimia symptoms in women with these conditions (Inaba & Cohen, 2004). As mentioned previously, women with severe addictions, particularly to alcohol, commonly suffer from malnutrition (SAMSHA, 2009). Alcohol hinders the body's ability to absorb nutrients and the addict may replace normal nutrient-rich food with bulky alcohol, which offers little nutrition beyond calories (Harvard Medical School, 2010, SAMSHA, 2011). It is well documented that patients who received bariatric reduction procedures, the majority of whom previously met eating disorder criteria, are at significantly higher risk of developing SUDs (Volkow, Wang, Tomasi, & Baler, 2012). The rationalization for this phenomenon is that binge eating is a type of addiction itself, affecting similar areas of the brain, and this is a type of cross-addiction between excessive eating and drug/alcohol use (Volkow et al., 2012; Inaba & Cohen, 2004). To illustrate this strong correlation, numerous studies reported between 15-20% of women receiving treatment for eating disorders also previously or currently met SUDs, a number hugely larger than males with eating disorders in chemical dependence treatment (Krahn, 1993; SAMSHA, 2013).

Women living with other severe psychiatric disorders, including psychotic disorders, personality disorders, and PTSD, are also more vulnerable to SUD (Magura, 2008; Briggs & Pepperell, 2009). Additionally, prolonged drug abuse frequently leads to permanent brain damage and can create psychosis (Inaba & Cohen, 2004). Similar to male counterparts, female addicts have higher rates of cluster B personality disorders, however these tend to be expressed as histrionic or borderline rather than the antisocial traits seen in men (Hasselbrock &

Hasselbrock, 1993). Women diagnosed with PTSD and SUDs are twice as likely to be involved in illicit drugs rather than in alcohol, and have the reputation of "being difficult" to treat because of the poor interpersonal skills they developed as a result of previous traumatizing relationships (Briggs & Pepperell, 2009, p. 67; Magura, 2008).

Many researchers have speculated why these differences exist and have concluded that beyond physical predisposition, women are significantly more likely to experience traumatic experiences, such as physical and sexual abuse, and that this is a major factor in women developing both mental health conditions and SUDs (Kluft, Bloom & Klinzie, 2000; Briggs & Pepperell, 2009). Consider that one in eight women will have been raped in their life, one in four women will have been sexually molested and over 70% of women reported witnessing traumatic events (Kluft, et al., 2000). There have many studies linking trauma and anxiety management to SUDs, that alcohol/drugs become a coping mechanism (Belt & Punamäki, 2007; Gerra et al., 2007; Briggs & Pepperell, 2009). Hence, people experiencing great amounts of trauma, such as abused women, are at higher risk of abusing alcohol or drugs frequently as a means of self-medicating untreated PTDS (Briggs & Pepperell, 2009; Kluft et al., 2000; Krestan, 2000). This abuse can be broken into three categories: childhood family-based abuse, intimate partner violence and violence suffered due to lifestyle changes as a result of addiction.

Karr-Morse & Wiley (1997) offer this perspective on infant abuse and neglect:

> Finally, you hear footsteps. A cold nipple is stuck in your mouth and you see a blurred back of someone leaving and you are sucking and turning to see them walk away, and the bottle falls over. And your mouth is empty and your eyes are hot and wet, your stomach still hurts. You are screaming for someone to help. You hear footsteps and see the arms sweep down and the hand you hope is reaching for you sticks the nipple in again but hard

> so hard this it hurts and you choke. The footsteps go away and you cry out. You mouth loses the nipple and your arms are beating and your feet kick the mattress. You are hungry and angry and scared. You are screaming to an empty room. (p. 288)

Imagine now that that little baby girl never learns kindness or affection from her parents as an infant, a toddler, or a preschooler and the aggressiveness escalates to undeniable abuse; this is the story for nearly two thirds of women entering treatment for SUDs (Swan, 1998). Karr-Morse and Wiley (1997) paint a grim forecast for such children and state that it is a myth that "we can fix any damage done early with love and attention later" (p. 301). Other authors and researchers have also reported that early child abuse and neglect permanently changes a person's biological and neurological functions (Gerra et al., 2009; Scaer, 2007). Simply stated, abused children suffer varying levels of brain damage as fear-reactive areas of the brain are strengthened and logical and sensory areas are under developed (Scaer, 2007). Gerra et al.'s (2009) "findings suggest the possibility that childhood experience of neglect and poor parent–child attachment may have a persistent effect on HPA [hypothalamic–pituitary–adrenal] axis function as an adult, partially contributing, together with genetic factors and other environmental conditions, to both depressive traits and substance abuse neurobiological vulnerability" (p. 95). The Center for Disease Control's (2011) report on adverse childhood experiences (ACEs) has been cited by many professionals ranging from medical doctors and social service professionals to mental health providers because it clearly demonstrates the connection between childhood trauma, lifelong impairments and early death. See Appendix A. In general, women who grew up under neglectful care providers "where they take on adult responsibilities as a child, including household duties, parenting of younger children, and emotional support of parents, are more likely to initiate drug and alcohol use" (SAMSHA, 2009, p. 19; Beattie, 2009). Stevens & Smith

(2005) found that more than 70% of women in treatment for SUDs have been sexually abused by the age of 16. Simply stated, child abuse and neglect make individuals more vulnerable to SUDs; in part, because it changes neuron activity and hormone production in parts of the brain either connected to addiction response or responsible for higher brain function and emotional regulation (CDC, 2011; Gerra, 2009; Scaer, 2007).

Psychologically, without proper bonding during these early stages of development a person is not able to fully achieve interpersonal connection in later relationships in life (Sigelman and Rider 2012). Jeffrey, an adult survivor of child abuse writes, "I thought it was ordinary for so long, that every kid lived the same kind of life I did. I didn't think it was anything unusual to see a kid get beat up or to see him come to school with a black eye or bruises, maybe a broken arm or something like that" (Karr-Morse & Wiley, 1997, p. 246). If abuse in supposedly loving relationships is seen as the norm for children, they frequently seek out these relationships in romantic partners later in life (James, 2011; Kluft et al., 2000). This pattern is particularly true for women learning a victim role, whereas men are more likely to become perpetrators rather than victims in romantic relationships (Hesselbrock & Hesselbrock, 1993; Kluft et al., 2000; Beattie, 2009).

Many women in treatment for SUDs who have a history of being a victim of childhood abuse/neglect develop what James (2011) describes as "damaged sexual self-esteem [that] can be viewed as a type of disability and has also been linked with sexual revictimization" (p. 231). Talbot (2007) discusses her own struggles with relationships and summarizes "I've had more lovers than birthdays" and how this still held true as she turned forty, concluding she was always searching for something and often fell into relationships which were ultimately damaging for her and led to heavier drinking (p. 122). One in eight women will be raped or sexually molested in

her life; as many as one in four women is in a relationship with somebody who has abused her, and many of these women turn to alcohol or drugs to cope (Kluft et al., 2000). Scaer (2007) states that these relationships lead to reoccurring traumatization which further strengthens neuro-pathways connected with instinctual responses while underusing pathways needed for higher level thinking and mood regulation. This "whiplash syndrome" is worsened by repetitive trauma, such as that found in abusive romantic relationships, and is a major source of posttraumatic stress disorder found in a disproportionately high amount of women with SUDs (Briggs & Pepperell, 2009; Scaer, 2007). To summarize, women in SUDs treatment are frequently drawn into abusive relationships because this is what they are used to from poor childhood relationships, and these abusive relationship only strengthen the trauma response and increase their vulnerability to PTSD, SUDs and other mental health concerns (SAMSHA, 2009; Scaer, 2007).

One gender difference becomes obvious in these damaging relationships; men with SUDs most frequently start drug use with male peers and women more commonly are introduced to drugs such as heroin and cocaine by a male partner (Briggs & Pepperell, 2009; SAMSHA, 2009). The SAMSHA (2009) TIP 51 confirms that "the actual introduction to substances by a significant other can be a way of increasing control and establishing power over some women" (p. 23). One study indicated that 60% of women in treatment for SUDs were currently or had previously been in abusive romantic relationships with men and 33% of women who experience domestic abuse report SUDs (SAMSHA, 2009; Stevens & Smith, 2005). It should be noted that similar to their male counterparts, homosexual females are at greater risk of developing SUDs than heterosexuals indicating that stigma and societal stressors play a significant role in the development of addiction (SAMSHA, 2009). Drugs become a tool to control and manipulate female victims in domestic abuse situations (SAMSHA, 2009).

James (2011) explains that women who were previous victims of abuse frequently are drawn to what they are accustomed to, violent controlling men, and in these un-equalized relationships women frequently use the drugs their partners are using upon their encouragement; in the process, leaving them at a more significant power deficit. As women slip deeper into addiction many suffer physical and sexual abuse, either through abusive romantic relationships or prostitution, in order to gain access to drugs (Briggs & Pepperell, 2009). The intoxication of the drugs/alcohol leaves a woman increasingly vulnerable and unable to defend herself, perpetuating the cycle of abuse and drug use (Briggs & Pepperell, 2009; SAMSHA, 2009). Some women turn to prostitution to acquire drugs, which is a dangerous field of employment in which physical and sexual abuse is routine (Briggs & Pepperell, 2009). Another branch of research indicates that adolescent girls forced into human trafficking situations are at higher risk of SUDs either because they use to self-medicate or are provided drugs as a form of chemical restraint or control measure (Bhunu & Mushayabasa, 2012; Briggs & Pepperell, 2009). Though the minority of women with SUDs fit this description, the majority of women working in prostitution, or who are victims of human trafficking, meet diagnostic criteria for SUDs (Bhunu & Mushayabasa, 2012). Analyzing these cycles becomes very complex as many elements are interwoven (Briggs & Pepperell, 2009). For many women living with SUDs, trauma and abuse continue or intensify as their addiction intensifies, and they become more dependent on abusive men to obtain their drugs (Bhunu & Mushayabasa, 2012).

Sociocultural Gender Differences

Though fast gains have been made in the past 150 years regarding women's rights in the United States, women remain a disparaged population, and nowhere is this more obvious than in the field of addictions treatment (Briggs and Pepperell, 2009). We live in a society where many

type of inequality are a reality; for example women face higher levels of poverty and have fewer opportunities than men of equal ability (Briggs & Pepperell, 2009; Falrudi, 1991). The stresses of poverty and social injustice can be a major consideration in SUDs as individuals struggle to manage financial stress or their addictions lead to further employment difficulties (Stevens & Smith, 2005). Additionally, women face different social expectations than men and many of these role are significantly affected by addictive behaviors which further increases the stigma women face in addressing their substance use problems (Briggs & Pepperell, 2009). Lastly, one must not forget racial considerations and specific expectations women face within their own subcultures (Krestan, 2000). Women face many unique barriers and special considerations including: social injustice concerns, stigma related to social role expectations, and racial gender roles; however, even with these sociocultural challenges women have unique opportunities in addictions recovery, seldom used by male counterparts.

It has become rather common knowledge that women make less than men in the workforce, a recent White House initiative (2013) has cited that this disparity is a growing family problem because many children are dependent on primarily their mother's income. The most recent government report stated full-time employed American women earn 23-46% less money than men, depending on race (White House, 2013). This can be explained by a variety of situations affecting women. Firstly, women, especially in lower socioeconomic communities or of racial minorities, are less likely to complete high school or post-secondary schooling frequently because of teenage or early unplanned pregnancy forcing them to focus on being mothers rather than students (Briggs & Pepperell, 2009; SAMSHA, 2009). The majority of these young mothers are single parents who struggle to be financially secure, often requiring them to settle for lower paying jobs requiring less education (Falrudi, 1993). Consider the addition of

SUDs behaviors into this equation and it becomes increasingly difficult to escape the financial trap as women struggle to remain responsible for multiple life roles in the face of their addiction (SAMSHA, 2009). Furthermore, educated women frequently enter fields, such as child care or teaching, which pay less than fields requiring the same level of education more commonly occupied by men, such as construction and engineering (Briggs & Pepperell, 2009). Moreover, women are typically paid 10% less nationwide for doing the exact same level of job and are frequently passed over for promotions within the organization (Briggs & Pepperell, 2009). For example, it is not uncommon for large human service organizations which employ 80% female staff to have the top 3-4 leadership positions held by men (Falrudi, 1993). It is difficult to fully comprehend the impact this devaluation has on women and the American culture as a whole; simply stated, American women are financially told their work is less meaningful/worthy than men's (White House, 2013). Surely this discrimination has an impact on the mental health of American women, and researchers have indicated it likely could be a factor in the development and exacerbation of SUDs in marginalized women (SAMSHA, 2009; White House, 2013).

Another consideration compounding the financial inequality is that women in cultures across the world are expected to be devoted mothers, wives, daughters and family care providers (SAMSHA, 2009). This further limits their abilities to pursue higher paying career pursuits as they are likely to work part-time (SAMSHA, 2009). Briggs & Pepperell (2009) state that women are held to higher social standards in regards to substance use and frequently hide drug/alcohol use from family, seeking treatment much later than ideal when problems have already escalated. Fen Sun & Picker (2001) add that stereotypical female roles depicted in television and film further limit girls understanding of social roles and women's role in society.

Fen Sun & Picker (2001) explain that although it has been a long standing multi-cultural construct that women must be paired with a man to be complete, happy and successful, the Disney cooperation has made millions further entrenching this idea through the Disney Princesses. These images of the vapid helpless and honestly stupid princess paint the image that women are unable to survive without a male partner to rescue them (Fen Sun & Picker, 2001). Briggs & Pepperell (2009) state that these images and self-perceptions are extremely harmful for women, especially those in SUD treatment or domestically abusive relationships. Wives of previous generations and other cultures were/are traditionally seen as property, a commodity that can be traded and sold for the political and social gains of husbands and fathers (Briggs & Pepperell, 2009).

In some respects, women of today's American generation are not so different, often being encouraged to marry a doctor or lawyer, somebody who can provide a secure future for them instead of becoming a doctor or lawyer themselves (SAMSHA, 2009). For most women marriage is a means of financial stability and social standing that they are not able to reach if not married, and there is a stigma against women remaining single professionals, a fear of becoming "an old maid" (Briggs & Pepperell, 2009). Much more so than men, women are socially defined by the role of their spouse; for the majority of married women this role is greatly valued often even to the level of superseding their own needs (Beattie, 2009). This strong role definition frequently becomes a barrier from (or distraction during) SUD treatment as women fear entering treatment because of the reaction of their spouse (SAMSHA, 2009). This fear is not unfounded as men are three times more likely to leave their wives receiving SUD treatment than women with husbands in treatment (SAMSHA, 2009). For women originally relying on their husband for financial support, this loss is not only psychologically and socially harming, but also

financially devastating which makes it a leading barrier to receiving treatment with over a third of women reporting stigma as the primary reason they did not seek treatment (SAMSHA, 2009). In short, because of the significance of the wife role in women's lives and American culture, women are deterred from seeking life-saving SUD treatment (SAMSHA, 2009).

One additional factor is that the majority of women were introduced to their substance of choice by a male partner and there is an emotional attachment which makes sobriety difficult, especially if their male partner continues to use (SAMSHA, 2009). "The relationship between spouses who are addicted is a strong influential factor" in a woman's choice to seek treatment or maintain sobriety (Briggs & Pepperell, 2009, p. 89). Professionals have recognized the strong correlation between home environmental use and relapse and have defined it as one of the six ASAM criteria dimensions when considering treatment level requirements (SAMSHA, 2009). Many professionals have argued that for women this is a significantly more important dimension than it is for men when considering their treatment needs because women are more likely to externally define themselves by relationships (Briggs & Pepperell, 2009).

Another major life role which defines women is strictly unique to women, the role of motherhood. This role can be either a barrier or a motivator for women facing SUD as women are frequently reluctant to seek treatment fearing that they will lose custody of their children or be labeled as unfit parents (SAMSHA, 2009). Carpenter (2012) examines the role media has in negatively labeling mothers with addictions as crack moms in need of punishment and reprimand-ation rather than redemption and treatment. Carpenter (2012) further explores the damaging impact this pop-icon image has of actual single mothers struggling with SUD as they are all but forced into hiding, further harming themselves and their dependent children. As stated before, the majority of women living with SUDS have been victims of less than ideal childhoods

themselves; these childhoods frequently include addictions, neglect and abuse. Without help these women's children are at much higher risk of falling into the same cycle addiction themselves (Beattie, 2009; Briggs & Pepperrell, 2009; SAMSHA, 2009). There is a certain irony that "the media war against the crack mom" actually feeds the very pattern it is judgmentally opposed to by making mothers less open to seeking treatment (Carpenter, 2012, p.2).

Even though the mothering role can be a barrier to seeking treatment it can also become a catalyst for periods of sobriety, especially during pregnancy (Massey et al., 2010; SAMSHA, 2009). Many have identified pregnancy as a time of urgency and "an opportunity for the treatment of substance use disorders in women" because one can capitalize on strong maternal emotions and desires to successfully fulfill the mothering role (Massey et al., 2010). Most women with SUDs will abstain during most of their pregnancy, allowing a window of sobriety which is a huge asset for treatment (Massey et al., 2010; SAMSHA, 2009). Effective treatment inserted during this window has been proven to prevent relapse following the birth of the child and promotes better parenting and health for the mother and child (SAMSHA, 2007). Massey et al. (2010) also found that abstaining during pregnancy lowered mothers' level of depression and anxiety and increased their feelings of self-worth as these women felt good about their choices relating to abstaining on the behalf of their unborn children.

As much as mothers praise themselves for abstaining during pregnancy women demoralize themselves for using during parenting which creates a cyclonic downward spiral of psychological challenges as cited previously (Briggs & Pepperell, 2009; SAMSHA, 2009). In these ways, women face both external and internal pressures, accounting for higher levels of guilt and shame than male counterparts relating to their role as a substance addicted parent (SAMSHA, 2009). Carpenter (2012) elaborates that even though the role of mother historically

has been a major focus in cultures since the beginning of civilization, stories and media presentations have continued to perpetuate the concept that mothers must be flawless and solely focused on being mothers. Modern media has painted extremely negative portrayals of mothers struggling with addictions, much harsher than those presented of fathers with addictions (Carpenter, 2012). Others researchers have found that women, particularly mothers of minor children, are frequently held to a higher moral standard by mainstream society than men, making addictions particularly challenging for them (SAMSHA, 2009 & 2012).

The care provider role of women extends beyond being a supportive wife and devoted mother as women frequently are responsible for aging parents, or take professions in which they are responsible for caring for others such as personal care attendants, nurses, teachers and child care providers (Laux et al., 2008; Mack et al. 2013). Women facing addictions may struggle to meet the demands of these jobs, in the process putting more vulnerable individuals at risk of harm; although men's work performance is frequently affected by the drug/alcohol use, it is not weighed by the same moral compass as women's because of the nature of the role (Beattie, 2009; Briggs & Pepperell, 2009; SAMHSA, 2012). In reality, there is a disconnect in society. On one hand, women are held in the highest regard as keepers of society, care providers of the community, mothers and wives (Beattie, 2009). On the other hand, in regards to addiction, they are criminalized for needing to be cared for themselves, even if that treatment could benefit all those they care for including an upcoming generation in their children (Bromberg et al., 2010; Massey, et al., 2010). In actuality, it is the role women hold in society as care providers that heightens the stigma associated with them when they suffer from addictions (SAMSHA, 2009).

Another important consideration when working with women is the impact that racial discrimination has on the addiction process and treatment (Krestan, 2000). In addressing this

topic it is of utmost importance to address cultural norms without perpetuating further prejudice and stigmatization (Krastan, 2000; Stevens & Smith, 2005). Level of acculturation, community and individual characteristics must be taken into consideration, and blind assumptions about individuals must be avoided (Krestan, 2000; Stevens & Smith, 2005). However, to ignore the impact marginalization has on mental health and addictions would be foolish as it is a major factor in determining risk of addiction, availability of services for treatment and treatment acceptance (Krestan, 2000; SAMSHA, 2009). As a whole, racial minorities in the US are less likely to have access to mental health services because of lack of insurance benefits (SAMSHA, 2009; White House, 2013). Additionally, racial minorities are less likely to seek treatment because of discomfort within the White majority focused treatment system and because of cultural values (Krestan, 2000). Becoming more culturally sensitive as field can help reduce stigma and increase treatment acceptance some, but counselors must also understand the various cultural values of different racial/ethnic groups which also limit addictions treatment seeking (Krestan, 2000; Stevens & Smith, 2005).

African American women frequently face many stressors not as commonly found in other groups within the United States (Krestan, 2000; Laux, et al., 2008). They are more likely to be single mothers, work in lower paying professions and live in multi-generational homes with parents, aunts or uncles (Krestan, 2000). All too commonly the father of their children is absent either because of imprisonment, early death or abandonment, further strengthening the need for this multi-generational support (Krestan, 2000; SAMSHA, 2012 & 2009). Due to many factors, African American women frequently have been exposed to more adverse childhood experiences (ACTs) and higher levels of violence and trauma; as a result, they are at higher risk for comorbidity of mental health and SUDs (Bromberg, et al. 2010; Carpenter, 2012; CDC, 2011).

Regarding SUDs, they are more likely to smoke crack cocaine than other populations of women and as a result, are at higher risk of cardiovascular complications (Carpenter, 2012; SAMSHA, 2012). Many African American communities are focused around the church and faith, commonly practicing Protestantism, which can serve as an important recovery tool for women with SUDs and must not be ignored as a therapeutic tool and support (Krestan, 2000). African American women, especially those who live in inner city locations, can frequently be seen as verbally aggressive by other racial populations and counselors are encouraged to see this as a coping strategy which helps them survive in this stressful environment (Krestan, 2000).

Conversely, Hispanic American women are commonly observed as being quiet and reserved, befitting of their cultural norms that the husband/father/brother is the head of the household (Krestan, 2000). In is not uncommon for Hispanic American families to place importance on extended families, frequently living in or near the same house and co-parenting nieces and nephews (Krestan, 2000). Though this support system is an important safety measure it can also make treatment complicated as there are many invested persons and relationships to consider (Beattie, 2009; Krestan, 2000). These relationships could be supportive, but are more frequently judgmental and critical of women's substance use, as it is far more common for Hispanic men to drink or use drugs than women, who culturally are commonly dissuaded from using even in moderation (Krestan, 2000). Traditionally, most Hispanic American women practice Latin American style Catholicism, a blending of Roman Catholic faith and native rituals, and in these faith communities women play an important spiritual role to their church and families (Krestan, 2000). Because of the current influx in this racial population in the US, the level of acculturation is an especially important consideration for counselors to be mindful of during treatment (Stevens & Smith, 2005).

Asian American women are one of the least seen populations in SUDs treatment, so there is limited information about this population in regards to treatment (SAMSHA, 2009). Physiologically, a handful of Asian ethnic groups genetically have lower levels of liver enzymes responsible for metabolizing alcohol and places them at higher risk of addiction and medical complications resulting from alcohol use (Harvard Medical School, 2010; Krestan, 2000). This danger is even more significant for women who tend to have lower enzyme levels to begin with (Krestan, 2000; SAMSHA, 2009).Some considerations when working with Asian American clients are traditionally, there is a strong sense of honor and duty to the family, especially the parents, and culturally, there is a strong stigma against mental health concerns and SUDs (Stevens & Smith, 2005). Some Asian cultures are more clan-based and it would not be uncommon for family members to attend assessment appointments or interventions if the family sees the addiction as a significant uncontrollable problem within the family system (Krestan, 2000). These interventions may outwardly appear cruel in their shame/blame delivery but fit with the cultural norms of this population and may be needed in the treatment process of these persons, but should be assessed on an case-by-case situation (Krestan, 2000; Stevens & Smith, 2005). Asian Americans may participate in either Eastern or Western religions but frequently practice some level of eastern philosophical values placing value on the community and family above the individual (Krestan, 2000). Because of these values, Asian Americans appear to have lower rates of addiction than other populations, especially among women, but also are less likely to seek treatment even when they do have these issues, potentially making them a challenging population to work with (Krestan, 2000; Stevens & Smith, 2005).

Native American women face different struggles including a certain level of generational identity crisis with the erosion of Native culture since the European immigrant invasion and

dislocation of Native tribes (Krestan, 2000). In the wake of these major changes, Native Americans currently exhibit the highest level of alcohol addiction in the country leading to higher levels of other social concerns such as domestic abuse, child neglect, unemployment and poverty (Krestan, 2000; SAMSHA, 2013). Native American women, especially those living on reservations often live in stress-filled homes which can trigger mental health concerns including depression, anxiety, and SUDs (Briggs & Pepperall, 2009).

Even with these struggles, Native cultures offer many recovery strengths including resilient proud nations who despite great oppression have kept important elements of their culture and individual identity (Krestan, 2000). For Native American men and women struggling with SUDs, reconnecting with traditional spirituality can be an important tool; for non-Native counselors it is important to be sensitive to this and refer clients to tribal resources instead of attempting to mimic spirituality without proper knowledge (Krestan, 2000; White Bison, 2014). Counselors with some competency and training might make use of sacred symbols including the medicine wheel, totem poles, eagles, spirit guides, or other animals, but must do so respectfully and only to the level of their experience and client's spiritual readiness (White Bison, 2014). White Bison (2014) is a Native American recovery movement which embraces some recovery elements similar to Alcoholics Anonymous and other 12 step groups which is specifically designed by Native Americans for Native Americans. This organization meets around the country but also has an active online community and can be a valuable tool for counselors working with Native American women and families with addictions (White Bison, 2014). Despite the challenges Native American women face regarding addictions, they have cultural and tribal strengths to help with recovery.

Socio-culturally, women with SUDs of all races and backgrounds face challenges which are quite different and stigmatizing compared to male counterparts (SAMSHA, 2009). The pressures society places upon women as care providers for their husbands, children, parents, and vulnerable persons in the community further exacerbate their mental health concerns and SUDs (CDC, 2011; SAMSHA, 2009). Additionally, media representations of women lead to further stereotyping of gender roles and criminalization of addiction (Carpenter, 2012; Feng Sun & Picker, 2001). Women tend to focus their lives and identities on their role and ability to be a successful care provider in these roles and when addictions impact their ability to meet these demands, the result can be crippling shame and self-blame (Bromberg et al., 2010; SAMSHA, 2009). Because of this externalized self-identification, women are more susceptible than men to sabotaging or negative relationship influences on their addiction recovery (Briggs & Pepperell, 2008; SAMSHA, 2009). For example, women may be more likely to seek supportive relationships with peers during their recovery but if peer relapses women tend to have a more difficult time maintaining sobriety themselves, especially if it is an exceptionally close relationship (Briggs & Pepperell, 2009).

Additionally, because of societal limitations many women face, women may become more reliant on men to financially support them, and in the lives of many women with SUDs these men frequently perpetuate the cycle of drug/alcohol use and/or domestic abuse (Belt & Punakaki, 2007; James, 2011). Clearly, women's unique role in American society is a significant factor in why women do or do not seek treatment for SUDs but it is also a major consideration when designing functional treatment plans which enable them to succeed in long-term recovery (SAMSHA, 2009). It is for these reason that Bronfenbrenner's (1979) systematic system can be used for addressing not only the individual woman in treatment, but also her surrounding social

groups, and society as a whole. See Appendix B for diagram illustrating this overlap. Many professionals in the field have concluded that unless women's microsystems are addressed, it is exceptionally likely they will not be successful in their SUDs recovery (SAMSHA, 2009 & 2012). Additionally, others have called for societal changes in the media, working to redefine women's roles and be more accepting of imperfections relating to SUDs at the macrosystem level (Bronfenrenner, 1979; Carpenter, 2009; Feng Sun & Picker, 2001).

Conclusion

Though this is an abbreviated account of the gender differences between men and women living with addictions, it is clear to see that treating women involves a complex web of physiological, psychological, and socio-cultural challenges (SAMSHA, 2009). Women represent a minority of clients seeking treatment for addictions because they are less likely to suffer from SUDs and cultural standards remain a significant barrier for them seeking treatment when they have a problem with drug or alcohol (Briggs & Pepperell, 2009; SAMSHA, 2009). However, women represent the fastest growing segment of American's living with addictions and professionals must be prepared for this influx of new patients (Harvard Medical School, 2010; SAMSHA, 2013). Counselors working with women with SUDs must be mindful of these complexities and treatment organization must make accommodations to better treat this growing population seeking treatment (SAMSHA, 2013 & 2009).

Because of the complex nature of the cyclical trauma the majority of women living with addictions face, this paper was not able to address some significant topics regarding SUDs treatment of women, most namely the impacts on family and children (Belt & Punakaki, 2007; Bromberg, et al., 2010). It is obvious that due to the importance of relationships and their impact on women's development and ability to recover from SUDs family system models, including codependency and feedback loops, is an area for further research (Belt & Punakaki, 2007; SAMSHA 2012). Another consideration when working with women, especially those with SUDs, is that they are most commonly the primary care provider for their children which means that their addictions impact their children's health and development (Bromberg, et al., 2010). Two potential areas of further research include further investigation into family systems relating to addictions in women and parenting concerns for mother with addictions and minor children.

One final area that could be covered in future research is how non-AODA licensed counselors can become better prepared to screening and addressing SUDs in women that they see for mental health concerns. As stated in this paper, women are more likely to seek mental health treatment than they are to seek addictions treatment (Magura, 2008). Because of the fast progression and significant health problems women with SUDs face early detection and treatment can truly be life-saving, and providers treating women with mental health concerns can be on the forefront of this (Harvard Medical School, 2010, SAMSHA, 2009).

Treating women with addictions can be challenging, but with proper training and cultural sensitivity counselors can become proficient in treating this growing population seeking SUDs treatment in both outpatient and residential facilities (SAMSHA, 2013). The complex nature of treating women within the current male-centric treatment models is flawed and required modifications to become more sensitive to the needs of women (SAMSHA, 2009).

Author's Note

The topic for this paper came to me while working at my internship site. Because I am on a dual license track I had taken many addictions courses. Through these I was aware of some gender difference concerning women in treatment, but it did not become clear to me until I saw this difference in the action.

During the first 2 months of my internship, I had the opportunity to tour various treatment options available at Gundersen Health Systems and also shadowed a great variety of specialties. I spent several days at the residential treatment facility for men, Unity House for Men (UHM), and the spent several days at the women's house, Unity House for Women (UHW). I very quickly noticed significant differences in the clients and the treatment approaches used with them. When I asked the manager of UHW, Linda, a field-worn veteran of working with women in addictions, about this difference she stated that "To treat women you have to get into their heads". She went on to explain that it is "more complex" because it is all about relationships and emotions including huge amounts of guilt and shame. I filed this insight in the back of my mind.

Soon after, I began seeing my own clients and began to understand more what Linda meant. I found that women were typically tearful and discussed all the people they hurt by their addictions during their intake assessments, and this was rarely true of men during that initial meeting. Men might talk about never having money, or "being sick of not getting anywhere in life"; they might talk about being sick of listening to people complain about them or that so-and-so made them come in for an assessment. Women, on the other hand, talked about being a disappointment to themselves and others they cared about (parents, spouses, children) and tended

to focus on external considerations and relationships. This was curious to me and I realized I needed to understand that situation better. Hence, I chose this as my capstone topic.

Over the past months I have established individual counseling relationships with several women working through their addictions. I have found that with these women much of our work is on building self-esteem and confidence in areas much broader than addictions, covering topics such as parenting, communication skills and career aspirations. Although some of this is common in working with men too, it seems to me that women take these roles in life more personally and react more emotionally. Additionally, I have come to realize what textbook meant by gender differences in trauma/abuse reactions. It seems that the male clients I have worked with who are diagnosed with PTSD or other trauma-related disorder and SUDs have a pattern of reacting angrily and may eventually avoid public settings to avoid conflicts or criminal charges. On the other hand, women with similar life experiences and diagnoses seem more likely to repeatedly find themselves in abusive relationships, often resulting in prostitution or using drugs to avoid conflicts with significant others. Also, unlike my male clients, women frequently must bring their children to appointments. I have begun providing toys, books and small treats to entertain them in a modified waiting area outside my office door; this keeps them busy but also puts the mother at ease as the child can easily access them if needed. This also has the benefit that the children like to have their moms come to appointments, taking some strain off the mothers. I have learned to make accommodations such as these for female clients I see individually.

I have also had the opportunity through my internship to work with a broader base of women and girls through co-facilitating two AODA treatment groups, one relating to relapse-prevention for adults and the other relating to adolescent treatment for ages 14-18. This has been

an eye-opening experience; I am able to see individuals at the beginning of their substance abuse history and those who have "hit rock bottom" and are recovering. Some of the common patterns I hear between these varied participants are eerily similar, and upon completing the research for this paper, seem to be tragically common. I hear the youngest participants say, "I would never do . . . " and the older group members say "I thought I would never do. . ." Somehow, I wish they could hear each other.

I feel that the information I gained from this project was directly applied to my work in both individual and group sessions. I believe I am a better counselor after learning more about the complexities of working with women with SUDs. I feel that I am better at assessing AODA concerns because of this project as I am more to sensitive and targeted in areas impacting women. For example, screening tools like the CAGE or TWEAK ask about morning use, and mothers without children typically won't use in the early morning. However, asking a stay-at-home mom if she needs a lunchtime drinking break she is more likely to answer yes because this is when the children are at school.

Upon reflecting on my experiences with this paper, I realize that writing the socio-cultural differences section was the most difficult for me, and I put off doing this part of the paper. I had to evaluate my own behavior and concluded once again I was faced with my own privilege. I am privileged to be born into a family that was stable enough and did not have addiction in its midst. I am privileged to be born of a racial and cultural background in which I am not faced with many of the challenges and barriers women born to minority cultures face. I am privileged to be born to an upper-middle class family in a strong generally safe community with a supportive extended family and other social supports. All these gifts I was given by grace; I did not earn these privileges and do not deserve them any more than anybody else. These

factors have been protective forces which in part have kept me from dangerous life patterns, including addiction.

I did experience another, more significant problem while working on this capstone project; namely, that there was way too much information available on the topic. Originally, I aimed to focus a large segment of this paper on family dynamics, co-dependency, generational cycles of physical/sexual abuse and family treatment modules. However, much of this portion of the paper was cut and bits were merged into other sections. This is an area of interest for me and in the future might be an area for further research. I want to better understand this cycle and be able to identify and implement interventions to prevent it from continuing. In short, I think about the children on the other side of my office door waiting with a handful of Cheez-its and a box of crayons for their mothers to return. Or, maybe I think about their mothers in the process of returning to sanity or recreating themselves through their treatment and what that must be like for these children. I have nothing but the upmost respect for the mothers I work with and admire their courage in working on their recovery and redefining themselves as women, mothers, daughters and spouses. I suppose this paper is dedicated to them. I also feel greatly indebted to my amazing clinical supervisor, LeeAnn who offered support, encouragement and resources for working with these complex cases.

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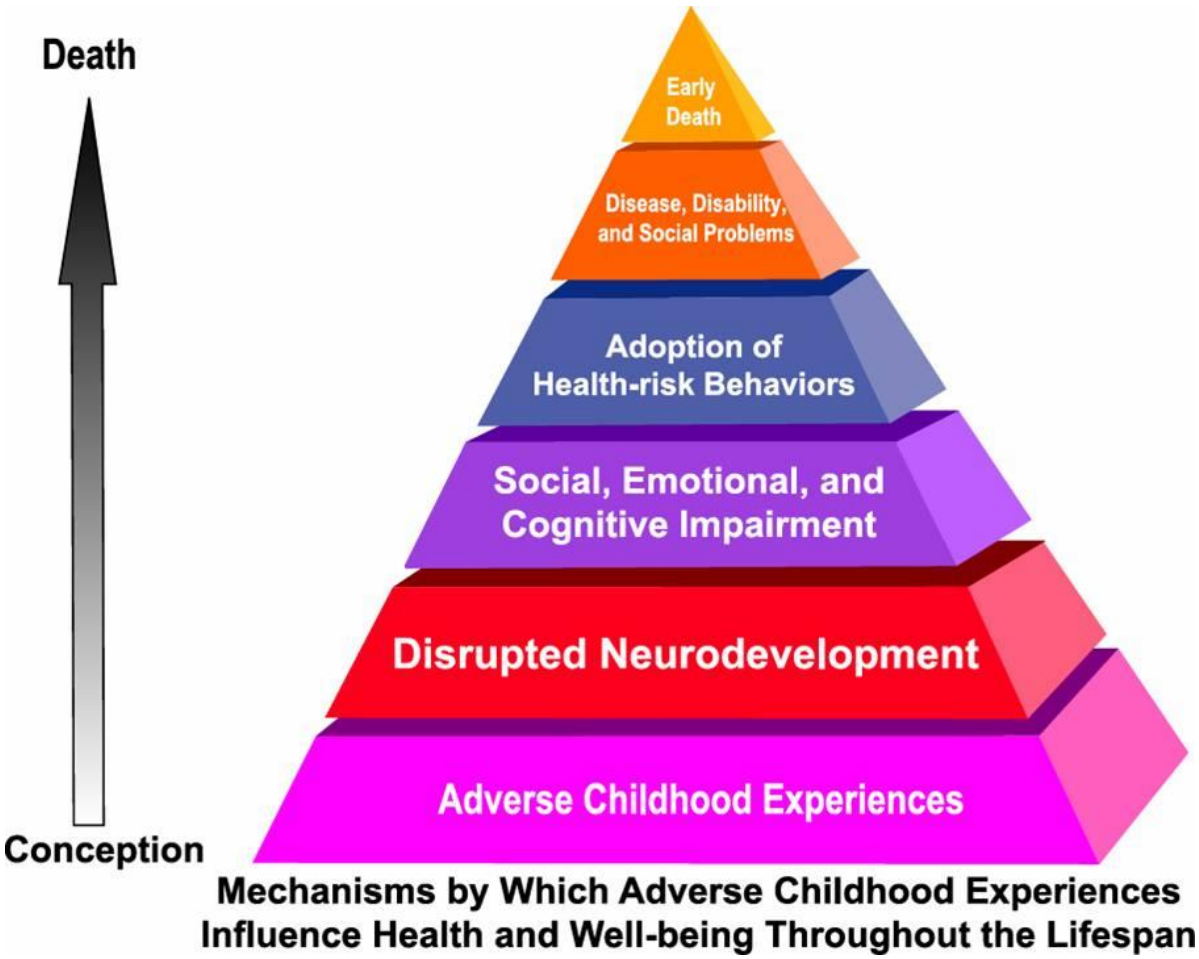
Appendix A

Adverse Childhood Experiences Pyramid



Appendix B

Systematic Treatment Considerations for Women