

**BARRIERS TO TREATMENT: AN ETHNOGRAPHIC STUDY OF SUBSTANCE-  
DEPENDENT WOMEN SEEKING TREATMENT**

by

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Substance abuse among women continues to increase; however, relatively few of these women seek addictions' treatment. Despite evidence suggesting that addicted women face diverse gender-specific barriers that deter them from seeking treatment and impede successful recovery if they do, few studies have focused on understanding the barriers, how they operate, and how they can be overcome by exploring the experiences and perceptions of substance-dependent women. This study will employ a three-group comparison design to investigate if, and how, the experiences and perceptions of substance-dependent women who overcome treatment barriers differ from those of women who do not. Data will be gathered in in-depth interviews with a purposive sample of 30 women who differ by race, ethnicity, and class; 10 will be inpatients in a treatment facility, 10 will be participants in an aftercare program, and 10 will not be in treatment. It is anticipated that the findings will address the crucial gap in extant research regarding the barriers substance-dependent women confront and how these barriers can be surmounted to facilitate successful recovery.

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## **1. Introduction**

### **1.1. Statement of the Problem**

Despite a recent increase in the number of substance abuse treatment programs accommodating women, there are still relatively fewer treatment programs for women than for men (Copeland, 1997). At the same time, an increasing number of women have problems of substance abuse (Cohen, 2000; Rasmussen, 2000). As a result, growing numbers of substance-dependent women are in need of treatment (Colby & Murrell, 1998; Weisner, Greenfield, & Room, 1995).

In addition to gender inequality in the number of treatment programs for women, there is also gender inequality in the appropriateness of the treatment that is available to women. For example, there are disproportionately more inpatient treatment programs for men than for women (Rasmussen, 2000). Moreover, most programs for women are modeled on programs that were designed for men, despite the fact that a growing body of research has identified gender-specific differences in treatment needs (Blume, 1998). For example, most treatment programs make no provision for child care (Carter, 1997; Cohen, 2000; Finkelstein, 1994). They may also discourage discussion of problems other than substance abuse, because for males substance

abuse is usually the primary problem, despite the fact that other factors, such as depression, are more often the primary problem for women (Copeland, 1997; Copeland & Hall, 1992). In addition, the majority of screening tools that are used to identify substance abuse in women were originally developed for men, and many of the items they contain are not necessarily relevant to women's experiences with substance abuse (Gomberg, 1999).

Moreover, gender inequality in the number and appropriateness of treatment programs may be exacerbated by gender-specific barriers to treatment. Preliminary evidence suggests that addicted women face barriers to treatment that are either greater than those faced by males or specific to their gender status and roles (Beckman & Amaro, 1996). These barriers, which range from lack of health insurance to lack of social support, are diverse and mutually reinforcing. Gender-specific barriers may exacerbate these in the treatment system due to inaccurate stereotypes about women who are substance dependent (Gomberg, 1999). As a whole, the barriers are believed to inhibit women from seeking treatment and impede their successful recovery if they do obtain treatment.

For many women, gender discrimination combines with discrimination based on racial or ethnic minority status and socioeconomic class. These intersecting factors may aggravate

greatly the problem of inequality of access to appropriate treatment. Women of color and working-class women may experience even greater barriers to treatment than middle-class Euroamerican women. For example, relative to middle-class Euroamerican women, they are less likely to have health insurance or to be able to afford child care so they can enter treatment. Nonetheless, research focusing on their specific needs and circumstances is rare (Blume, 1998; Gomberg 1999). Cultural differences may also raise additional barriers to treatment for many minority women (Cohen, 2000).

The reasons for the gender inequality in women's treatment are the concomitant gender blindness and dominance of male models in substance dependency research. Despite an increasing awareness of gender-specific responses to substance abuse and treatment, these biases still remained evident in the research as late as the 1990s (Blume 1998; Brett, Graham, & Smythe, 1995). Even then, most of the research consisted of studies of and by men, measuring variables relevant to men's experience.

Like most sociological research, the majority of research on substance abuse has sampled only men, and what has been learned about men has been presumed to apply equally to women. In the limited substance abuse research that has included women, researchers have often simply added gender as a variable, while using the same masculinist theories and methods.

Previous substance abuse research has also been dominated by studies of objectively measured attributes (such as the amount of alcohol consumed and occupation) of very large numbers of 'subjects.' This type of positivist research, even when it includes women, also reflects male bias. This is because the more subjective and emotional aspects of informants' lives are perceived as being of little or no interest, even though these are likely to be the most important aspects of women's experiences (Andersen, 1983). Although some researchers have concluded that there is a need for further research to understand how the variables interact at the micro level, that is, at the level of the individual informant, there is a dearth of research on the perspectives of individual informants themselves, and particularly substance-dependent women.

The gender discrimination and gender blindness in substance abuse research are a reflection of masculinist bias in sociology in general. Feminists believe that such masculinist bias is part of the larger context of male hegemony over women in Western society and especially in the United States (Andersen, 1983). For example, women are still denied equal access to quality educations, academic research positions, and professional advancement. As a result, they have had and continue to have less opportunity to influence the direction of research in many fields, including sociology. In addition, the needs of women are

downplayed in male-dominated society, making research into their unique problems and circumstances seem less pressing. Women who elect to do research in these areas may have their work denigrated as less credible or important than research reflecting the more usual masculinist biases.

Regardless of the causes of masculinist bias in research on substance dependency, the results of it are inarguable: The male experience of substance abuse has been articulated to the detriment of understanding the experiences of substance-dependent women. This had led to a flawed consensus regarding the problem and the manner in which it should be resolved, such that most treatment facilities discriminate against women either by offering them no treatment at all or by offering inappropriate treatment that is based on the needs of men and not their unique needs as women. The masculinist bias in substance abuse research must be surmounted in order to understand the experiences of women and design treatment programs tailored to their needs (Cohen, 2000). The previous research distorts the social reality it purports to explain, so it cannot be relied on to provide valid findings about women's needs (Andersen, 1983).

To overcome pervasive male bias, it is not enough to simply include women in objective, quantitative studies based on male models. What is needed, instead, is phenomenological research

that aims to understand the experience of substance abuse in women, from the viewpoint of the women themselves. The need for this type of research is supported by numerous studies (reviewed in Gomberg, 1999), which suggest that, for women at least, it is not negative life events per se that lead to substance abuse and barriers to treatment; rather, it is how individual women respond to these events.

In sum, the problems of providing treatment for addicted women appear to go well beyond the inadequate number of treatment slots. Barriers must first be understood as they are perceived by addicted women and then addressed in the design of treatment programs. Otherwise, simply expanding existing accommodations for women will prove to be an inadequate solution to a burgeoning social problem.

## **1.2. Research Questions**

Consideration of these problems prompts a number of important research questions. First, what can we learn about barriers to treatment and how they may be overcome by understanding the viewpoints of substance-dependent women who have overcome the barriers and those who have not? Second, what gender-specific barriers to treatment and recovery are identified by substance-dependent women, both those who have overcome them by their involvement in a treatment program and

those deterred from seeking treatment? Third, what are the differences in experiences and perceptions of and overcoming barriers to treatment and recovery among substance-dependent women who differ by race, ethnicity, and class? Fourth, and to explore what the perceptions of substance-dependent women can tell us about a possible treatment model that is accessible and effective, how important is gender sensitivity in treatment programs, as evaluated by women who have sought treatment and those deterred from doing so, in helping to overcome barriers to and remain in treatment?

### **1.3. Purpose of the Study**

The purpose of this study is to increase our understanding of the barriers to treatment and recovery faced by substance-dependent women, including what the barriers are, how they operate, and, importantly, how the barriers may be overcome. The study uses a phenomenological approach to provide insights into the barriers and overcoming them, from the perspectives of dependent women themselves, including women who differ from one another in race, ethnicity, and class. The study focuses on how women perceive and respond to the events in their lives by utilizing qualitative methods that provide in-depth understandings of social processes as they are interpreted and assigned meaning by those who experience them.

Asking women to describe their experiences in their own words increases the accuracy, complexity, and validity of data and guards against researcher misinterpretations. This approach not only validates women's authority on their own experiences, but allows the women themselves to generate theories not considered previously by researchers. The research here will provide much-needed information on the social and emotional contexts within which dependency develops and can be overcome. Moreover, while a number of studies in this area present comparative data between men and women, no study to date has compared different groups of women. This study will do so with a sample comprising substance-dependent women who are not in treatment, who are in a woman-centered residential treatment facility, and who have 'graduated' from that facility and currently participate in its aftercare program. Such a comparison has a twofold advantage: first, it will increase our understanding with regard to how differing perceptions may impact treatment seeking and recovery; and second, in eliciting these women's perceptions of or experience with types of programs that attend to gender-specific needs, it will provide a basis from which to draw conclusions about possible models of gender-sensitive programs more generally.

#### **1.4. Rationale of the Study**

By its nature, the proposed study avoids many of the masculinist biases that characterize most previous substance abuse research. For example, the study sample includes only females. The study also collects subjective data that reflect the personal experiences, perceptions, and feelings of individuals, rather than objective data that are devoid of any personal meaning or emotional content and that reflect only quantifiable attributes of samples. Since much of the research in this area suggests that the substance abuse experience of women differs significantly from that of men, the study's research questions and interview guide are drawn from the limited number of studies of substance abuse in women, rather than from the far more numerous studies of men. Finally, the proposed study incorporates the perceptions of women of different races, ethnic groups, and classes, rather than assuming that gender is a uniform category or experience regardless of these other factors. Research of this type is mandatory for a full understanding of barriers to treatment and how they can be overcome in the growing number of substance-dependent women.

## **2. CHAPTER II**

### **2.1. Review of the Literature**

The relevant literature on women and substance abuse treatment can be placed into four general categories. The first category includes studies that document the masculinist bias in previous substance abuse research. The second category of studies presents statistics on the incidence of addiction in women and the numbers of women in treatment programs, establishing the need for more treatment programs for women. The third category of studies preliminarily identifies barriers to treatment that addicted women face. The fourth category includes studies that investigate how race, ethnicity, and class are related to substance abuse and treatment in women.

### **2.2. Masculinist Bias in Substance Abuse Research.**

Two of the landmark studies that have most shaped our understanding of substance abuse are Jellinek's (1952) study of phases of alcoholism and Vaillant's (1995) 45-year longitudinal study of alcohol abuse. Both of these studies, as well as

virtually all other substance abuse studies undertaken prior to the women's movement in the early 1970s, are limited to male subjects, yet their results have been presumed to apply equally to females (Wilsnack, Wilsnack, & Sturmhofel, 1994). For example, Vaillant's work has led to the erroneous but widely held belief that substance abuse is the primary problem for people with co-occurring substance abuse and mental health problems. While this is most often the case for men, for women, mental health problems are more often the primary problem.

Early studies that did include women often failed to report the data, apparently dismissing it as too anomalous to bother reporting (Blume, 1980). Although several more recent studies have included women and also reported the findings, they have often simply added gender as another variable, similar to occupation or educational level. While including women in their samples, they continue to use the same old masculinist-biased theories and methods. They are typically large-scale surveys designed to measure the objective, quantifiable variables that appear to be relevant to men's experience, instead of in-depth, qualitative studies designed to gain insights into personal histories, self-perceptions, and feelings that may be more important to understanding women's experience (for examples of masculinist-biased studies that sample women, see Caetano &

Clark, 1998; Curran et al., 1999; McCarthy et al., 2001; Nielsen & Ford, 2001; Parker & Harford, 1992).

Because assessment of substance abuse is the first stage in treatment, screening tools merit examination in this context as well. The most widely used screening tools to identify substance abuse, including the MAST, CAGE, and AUDIT, were developed for men and have been found to be inadequate for screening female populations (Blume, 1998; Gomberg, 1999). Although screening tools have been designed specifically for women (Blume & Russell, 1993; Russell, Martier, & Sokol, 1991; Sokol, Martier, & Ager, 1989; Spak & Hallstrom, 1996), the older, male-biased tests continue to be used for women as well as men (Blume, 1998; Gomberg, 1999).

### **2.3. Need for Treatment Programs for Women.**

By the 1980s, it was becoming evident that the drinking patterns of women in the United States had changed over the past several decades: More women were drinking and more of them had drinking problems (Blume, 1986). This was found to be especially true in younger cohorts of women. The use of illicit drugs by women has also increased dramatically in recent decades, and females now account for about 40 percent of illicit drug users (Cohen, 2000; Rasmussen, 2000).

In response, between 1990 and 2000, the number of substance abuse facilities offering specialized treatment for addicted women increased by 53 percent (Cohen, 2000). However, this was still far from adequate to meet the needs of the growing population of addicted women (Colby & Murrell, 1998). This is reflected in the fact that there are half as many females as males with alcohol problems in the general population but only a quarter as many females as males in treatment (El-Guebaly, 1995; Schober & Annis, 1996). Despite increased efforts to enroll women in substance abuse programs, only 14 to 15 percent of women who need treatment are likely to receive it, compared with 23 percent of men (Dawson, 1996; Rasmussen, 2000).

#### **2.4. Barriers to Treatment.**

In 1986, Beckman and Amaro assembled the first comprehensive review of the existing literature on the causes of women's underutilization of substance-abuse treatment programs. The relatively limited number of studies then available generally adopted 'barriers to treatment' as the analytical framework for explaining why substance-abusing women are deterred from seeking help at alcohol and drug treatment programs to a greater extent than their male counterparts. Beckman and Amaro proposed that female addicts face higher and

different hurdles to treatment of their addiction than do male addicts.

Since then, a small but important body of studies of female substance abuse has been undertaken. Their collective findings suggest that substance abuse in women differs significantly from substance abuse in men and point to the potential validity of the 'barriers' conceptual framework of Beckman and Amaro (Cohen, 2000; Rasmussen, 2000; Schober and Annis, 1996). The studies propose that women are impaired in their ability to seek and receive help with their substance abuse problems by a wide array of gender-specific forces and factors. These can be grouped into four general categories: Women's role as mothers; the social stigma, negative self-perceptions, and depression that tend to characterize substance-abusing women; their relatively high risk of family abuse and victimization; and their relative lack of social support. The amount of research done on each area is scant, and the conclusions drawn remain tentative.

#### **2.5. Women's Role as Mothers.**

Although a small proportion of male substance abusers have sole custody of minor children, women are far more likely to be caring for children at home than are their male counterparts (McMahon & Luther, 1998). Lack of viable childcare alternatives

and, for many women, fear of child custody loss, have been proposed as the most pervasive barriers for women contemplating entry into substance abuse treatment (Allen, 1995; Carter, 1997; Cohen, 2000; Copeland, 1997; El-Guebaly, 1995; Finkelstein, 1994; Nelson-Zlupko et al., 1996). Fears of child custody loss are especially likely for women who depend on child welfare, including those who are single mothers, of low socioeconomic status, or members of racial or ethnic minority groups (Colby & Murrell, 1998).

Because treatment programs are typically based on the needs of men, provisions for child care are rarely made (Carter, 1997). The studies pertinent to this area suggest that, as a result, women who want help for their substance dependency are often forced to choose between inpatient treatment--and voluntary relinquishment of their children--or outpatient treatment alone (Cygnus Corporation, 1995). Paradoxically, while substance-dependent women express concern about the impact of their substance use on their children (McMahon & Luther, 1998), in order to care for their children they are forced to rely on less intensive outpatient treatment programs, which may not address the scope of their problems. Even women enrolled in 'day' treatment programs face problems finding care for their young children while they are attending the programs (Nelson-Zlupko et al., 1996).

Although pregnancy may serve as a powerful incentive for some women to seek help for substance abuse, studies suggest that the desire for help is often countered by feelings of guilt and fear (Cohen, 2000). A major cause of guilt is social stigma, which is discussed below. Pregnant women may also feel guilty about potentially harming their developing fetuses because of their alcohol or drug use. Fear may be caused by the threat of punitive measures, which purport to reduce prenatal substance abuse through the imposition of criminal penalties. The threat of punitive measures may actually have the reverse effect by discouraging pregnant women from seeking help for their addiction (Rasmussen, 2000; Stoli & Hill, 1996). Indeed, such measures may discourage pregnant substance abusers from seeking any form of prenatal medical care at all (Resnik, Gardner, & Rogers, 1998).

Even if pregnant women can overcome feelings of guilt and fear and do seek help, the number of residential substance abuse programs that can accommodate pregnant women is extremely limited (Resnik et al., 1998). As a result, only about 12 percent of pregnant women get the treatment they need (Center on Addiction and Substance Abuse, 1996).

The literature relating to the mother role points to the importance of this factor in understanding women's substance dependence and their willingness or ability to seek treatment.

Despite its apparent significance, however, very little research has been undertaken to ferret out the correlation between treatment seeking and the perspectives substance-dependent women themselves hold with regard to motherhood.

Empirical studies, for the most part, have maintained a positivistic approach, drawing conclusions from large-scale survey data comparing male and female samples that provide little illumination of the perceptions held by women. Even Beckman and Amaro's (1986) landmark study, while employing personal interviews, relied heavily on standardized scales and structured questions based on the researchers' perceptions of possible barriers to treatment. Their methods, therefore, were generally irrespective of the women's perceptions. The Allen Barriers to Treatment Instrument (Allen, 1994), though developed specifically around women's perceptions of barriers, is also quantitative. Two exceptions are the qualitative studies carried out by Nelson-Zlupko et al. (1995) and Smith (1999). The former, a small-scale exploratory study, focused exclusively on women's perceptions of treatment program effectiveness and elucidates only the importance of childcare provisions. The latter study used focus groups including both substance-dependent mothers and substance abuse providers. It has been argued elsewhere (Finkelstein, 1993; Carter, 1997) that service providers, many of whom embrace the 'bad woman-bad mother' stereotype, often

intensify the stigma felt by addicted women. This may have impacted the mothers' willingness to speak openly about their experiences.

Given the prominence of place tentatively assigned to the mother role as an impediment to treatment, a number of researchers have suggested that future studies should encompass female-only, parenting or pregnant samples and in-depth, gender-specific questions. The approach of this study addresses previous limitations and provide missing data by employing a women-only sample and an open-ended and semi-structured interview guide specifically designed, in part, to garner the perceptions of substance-dependent women with regard to the role of mother and its potential as a barrier to treatment.

## **2.6. Social Stigma, Negative Self-Perceptions, and Depression.**

Whereas the male-dominated society accepts and even encourages drinking among males, alcohol use by females carries connotations of promiscuity, immorality, and 'unfeminine' behavior (Cohen, 2000). Several studies suggest that women with drug and alcohol problems perceive a greater stigma attached to substance use in women than men (Carter, 1997; Cohen, 2000; Copeland, 1997; Gomberg, 1988; Schober & Annis, 1996). It is argued, as well, that perceptions of social stigma are

compounded for women who are mothers because of the predominant cultural attitude that women who abuse alcohol and illicit drugs are 'bad mothers' (Cohen, 2000; Colby & Murrell, 1998; Finkelstein, 1994).

In part because of the greater stigma attached to substance abuse in women, they are much more likely than men to experience feelings of shame, embarrassment, and guilt on being diagnosed as alcoholics or drug addicts (Thom, 1986). The extant studies suggest that these feelings of shame and embarrassment about their substance abuse may lead women to have a poor self-concept and low self-esteem. Stigma and guilt may also encourage women to drink alone in order to conceal their drinking from others. In fact, women have solitary drinking patterns to a far greater extent than men, who are more likely to drink in social settings such as bars (Annis, Graham, & Davis, 1987; Carter, 1997; Cohen 2000). All of these factors may work together to inhibit substance-abusing women from getting the treatment they need.

Issues of social stigma and negative self-perceptions have led many researchers to assume that women are more likely than men to be in denial about their substance abuse problems (see, for example, Thom, 1986; Wilson and Anderson, 1997). These researchers claim that denial explains why women are less likely than men to seek and obtain treatment in substance abuse facilities and more likely to turn to mental or medical health

care settings instead. The researchers also say it is because of denial that women are far less likely than men to identify substance abuse as their primary problem, even after they have entered treatment for substance abuse or been convicted of drug-related crimes, identifying instead depression or stressful life events as their primary problem (Thom, 1986; Wilson and Anderson, 1997).

Interpreting these behaviors as denial appears to be yet another example of masculinist bias. Although substance abuse usually is the primary problem in men who also have mental health problems (Vaillant, 1995), for as many as two-thirds of women depression is the primary problem and substance abuse is secondary (Gomberg, 1986; Helzer and Pryzbek, 1988). Women are likely to receive much needed treatment for depression or other mental disorders when they use medical and mental health care settings. However, if their concurrent substance abuse problems are not identified, the problems may be ignored, and the women may be prescribed psychoactive drugs that put them at risk for the abuse of prescription drugs as well (Cohen, 2000; Dawson, 1996; Weisner & Schmidt, 1992).

Gender-focused research in the areas of stigma and negative self-perceptions as barriers to treatment is sparse. This dearth is particularly surprising when considered against the vast evidence that perceptions of self are important determinants of

long-term behavior change (for example, see Howard & Callero, 1991; Rosenberg & Kaplan, 1982). The research that has been done in this area, like that with regard to the mother role, is primarily quantitative, with conclusions drawn from large-scale male-female comparative studies (i.e., Dawson, 1996; Weisner & Schmidt, 1992). Although a number of researchers (i.e., Dawson, 1996) have called for additional research regarding gender differences in initiating treatment, Shober and Annis (1996) specifically argue that the field will move forward only with a systematic exploration of women's perceptions and interpretations. Stigma, negative self-perceptions, and feelings of depression are- examined in this study in just such a manner through interview questions that probe if and how they inhibit "treatment seeking".

### **2.7. Abuse and Victimization.**

A history of victimization is among the strongest predictors of substance abuse in women (Schober & Annis, 1996). Several studies have documented that women who have experienced childhood sexual abuse or sexual assault as adults face a greater risk of developing alcohol dependency (e.g., Courtois 1988; Miller, Downs, & Testa, 1993). A number of studies have also found significantly higher rates of sexual abuse in

addicted women as compared with addicted men (Copeland and Hall, 1992; Rasmussen, 2000; Root, 1989). In addition, parental alcohol abuse appears to be significantly more common among alcoholic women than alcoholic men (Curran et al., 1999). While a family history of alcoholism and violence is linked with current alcoholism for both men and women, the association has been found to be much stronger for women (Chermack et al., 2000). In short, familial substance abuse, violence, and victimization are especially common in female addicts.

Existing research proposes that the experience of abuse can inhibit "treatment seeking" and recovery by contributing to depression, low self-esteem, and feelings of powerlessness, all of which are argued to be endemic among substance-dependent women (Cohen, 2000; Wilson & Anderson, 1997). These feelings, in turn, may act as barriers to successful recovery by diminishing expectations that one has the power to achieve a successful outcome.

Abuse is a widely researched topic and the construct appears frequently in the substance abuse treatment literature. Here again, however, the studies are predominantly quantitative. Samples are large-scale and the data is survey driven. Not only do studies in this area continue the male-female comparisons, the use of structured diagnostic interviews, self-report surveys, and structured questionnaires ignore the role of

relationships and the manner in which perceptions of these might hinder boundary setting and increase low-self esteem in addicted women. Interestingly, research in this area not only gives little prominence to women's experiences, but also focuses primarily on childhood history of family violence and alcoholism and fails to address abuse beyond family of origin. The present study tackles these flaws by examining lifetime experiences of abuse, how these are perceived by each woman, and if and how they impede treatment utilization.

#### **2.8. Lack of Social Support.**

A number of studies have proposed that a profound lack of social support is a major obstacle women face in seeking treatment for addiction. Whereas men are frequently prompted by spouses or other partners to seek help for addictions and to remain abstinent, for women the reverse may be true. In fact, addicted women are often involved in a relationship with a partner who shares their addiction. The research suggests that this codependent relationship may be a frequent, perhaps central, barrier to women's seeking treatment and subsequent recovery (Zelvin, 1999). It has been argued that male co-addicts typically encourage their female partners to continue their drug

or alcohol use, whereas the opposite is far less likely to occur (Cohen, 2000; Leonard & Das Eiden, 1999).

The social networks of female substance abusers may generally offer minimal support for recovery and may, in fact, actively discourage sobriety (Beckman & Amaro, 1986; Miller, 1998; Thom 1986, 1987; Wilsnack & Wilsnack, 1991). For example, in a study of gender differences in natural recovery from alcohol dependence, women reported being under less social pressure to end or reduce their drinking (Bischoff et al., 2000). This implies that, in general, women may be 'protected' from their drug or drinking problems by the people close to them. Not only may the abusing woman attempt to hide her problem because of the stigma, but in addition the abuse may be ignored, downplayed, or 'swept under the carpet' by well-meaning family members who are ashamed or embarrassed by the stigma of having a female alcoholic or drug abuser in the family. This is exacerbated by the tendency of the medical establishment to fail to recognize alcohol and drug problems in female patients (Reid, 1996; Rhodes & Johnson, 1994; Turnbull, 1989).

Most of the empirical studies involving social support as it relates to addiction and treatment seeking maintain a quantitative approach. The questionnaires and surveys, more often than not, reflect the perceptions of those who designed them, rather than of those whom they are designed to study

(i.e., Beckman & Amoro, 1985). They ferret out the patterns but not the reasons behind or importance of those patterns for the female addict. The suggestions made for future research in this area typically involve the need for studies on more diverse samples that will help document the significance of personal and social difficulties for women entering treatment. Turnbull (1986), in fact, argues that the influence of such environmental factors as support and stress on women's addiction, which not only make substance abuse in women different from but more complicated than that of men, must be validated and understood from the addicted woman's point of view. This research does so by investigating the manner in which women perceive a broad spectrum of social supports as inhibiting or enabling the treatment-seeking process.

### **2.9. Race, Ethnicity, and Class.**

Many researchers are convinced that gender alone is insufficient to explain the unique experiences of females. They argue that race or ethnicity and socioeconomic class, not just sex at birth, substantially shape women's lives, including their gender identification and behavior (e.g., Abel, 1995; Alcoff, 1995; Andersen & Hill, 1992; Berberoglu, 1994; Lugones and Spelman, 1995). This is why Collins (1995) argues that any

thorough analysis of gender must be attentive to issues of race, ethnicity, and class and incorporate the potentially varying perspectives of a diversity of women, not just the perspective of middle-class Euroamerican women.

Gender intersects with class in that numerous studies have demonstrated a strong association between substance abuse in women and low socioeconomic status (e.g., Herd & Grube, 1993; Parker & Harford, 1992). For example, women in treatment for alcohol abuse are more likely to be unemployed, or earn low incomes, and have few economic resources, as compared with their male counterparts (Beckman & Amaro, 1986; Carter, 1997; Weisner & Schmidt, 1992). Studies have suggested specific ways in which low income can have an inhibitory effect on the entrance of substance-abusing women into treatment. Treatment not only costs money in direct payments, but there are indirect costs such as transportation costs, as well as foregone income (Copeland, 1997; Beckman and Amaro, 1986). It should be noted that the direction of causality between low socioeconomic status and substance abuse is not necessarily one-way. It is likely that substance abuse is a cause as well as a consequence of low socioeconomic status, at least for some women.

Low income women must often rely on support services and thus may face additional, institutional barriers to treatment. For example, low income women are far less likely to have health

care insurance coverage, so their only major source of financial support for medical treatment is likely to be Medicaid (Carter, 1997; Young, 1996). Many treatment providers are reluctant or unwilling to accept Medicaid reimbursements (National Center on Addiction and Substance Abuse, 1998).

In general, there is a daunting maze of local, state, and federal agencies low income women must deal with, and they may already be alienated from and distrust the social welfare system (Cohen, 2000; Colby & Murrell, 1998; Finkelstein, 1994). Their alienation and distrust are understandable, given that they are likely to be shuttled between welfare, mental health, child care, and family service systems instead of receiving the services they need (Cohen, 2000).

Racial or ethnic minority status also intersects with gender in substance abuse. Several studies of substance abuse that have included informants of different racial or ethnic minority groups have proposed significant differences between the groups in their patterns of substance abuse and treatment. Markarian and Franklin (1998), for example, review several studies of substance abuse in women from minority populations. Among other relevant findings, the studies report that a larger proportion of Hispanic and African American women than Euroamerican women are heavy drinkers, placing these groups at higher risk for developing drinking problems (see also Caetano &

Clark, 1998). The studies also report that minority women are more likely to abuse drugs, less likely to be successfully treated for their addiction, and more likely to have alcohol-related health problems than Euroamerican women (e.g., Bowser & Bilal, 2001).

A barrier to treatment that many minority women may face is the failure of treatment programs to acknowledge and appreciate their values, beliefs, and practices because they differ from the majority Euroamerican culture. As a result, minority clients may feel misunderstood or skeptical about the usefulness of treatment, leading them to drop out of treatment altogether (Castro et al., 1999; Echeverry, 1997).

A number of studies have found that race, or ethnicity, and class are also intersecting variables, particularly for substance-abusing women. Minority women tend to have marginalized status by virtue of their ethnicity or race as well as by virtue of their gender and substance abuse. Therefore, they are especially likely to have low incomes and all the barriers associated with low socioeconomic class.

Both low income and minority women are also more likely to have checkered or nonexistent work histories and to lack educational qualifications and vocational skills. As a result, they are more likely to turn to crime to support themselves and their addictions (Booth, Koester, & Pinto, 1995; Wilson and

Anderson, 1997). This, in turn, creates a whole host of barriers to treatment and to maintenance of sobriety after treatment.

In general, minority women have been included in samples solely to mirror the demographic make-up of a particular area. Rarely are their responses distinguished from those of other participants. They are most often a component of the gender variable only, despite the fact that several researchers have suggested the need for more diverse samples to fully address the factors that inhibit or promote treatment utilization. The near-complete invisibility of minority women is addressed here as their experiences and perceptions with regard to treatment utilization are explored. Their experiences and perceptions comprise a substantial part of the data. Moreover, the demographic data allow for an investigation into the interconnection among race, ethnicity, and class and if this influences treatment utilization.

#### **2.10. Conclusion.**

The literature surveyed in this review attests to a masculinist bias in previous substance abuse research and to gender inequality in the number, appropriateness, and use of substance-abuse treatment programs for women. The literature also proposes the existence of an extremely diverse array of

barriers to women's entrance into treatment, many of which are mutually interactive and reinforcing. Finally, the literature suggests that race and class differences may intersect gender differences and exacerbate barriers to treatment for many women.

Of most relevance to this study is the need to enhance understanding of women's barriers to treatment and to do so from the perspectives of addicted women. While the few empirical studies centering on this issue have made essential contributions to an awareness that substance-dependent women may confront different challenges and barriers than those confronted by substance-dependent men, the methodologies used rarely draw out the subjective experiences of women as they relate to the barriers. The studies propose that the mother role, negative emotional states, the lack of social support, and abusive relationships impede substance-dependent women from seeking treatment, yet, without systematic exploration of women's perceptions and experiences, the findings remain preliminary and tentative.

The findings are limited by a heavy reliance on quantitative instruments. Although valuable for obtaining valid and reliable reports of consumption patterns and amounts, objective data are less useful in eliciting the perceptions and subjective experiences of substance-dependent women, which may be vital for understanding their motivation or ability to seek

treatment. Even studies using a more qualitative approach frequently have drawn conclusions from data based on researchers' preconceptions and thereby have diminished the perceptions of the addicted women.

The objective research that pervades this topic has not attended to the subjective experiences of substance-dependent women. The neglect of women's subjective experiences allows no clear linkage between psychosocial experiences and service utilization and subsequent recovery, a link that must be accomplished in order to move this field of study forward. The goal here is to move the field forward through research designed to draw its findings based on the experiences and perceptions of substance-dependent women.

### 3. CHAPTER III

#### 3.1. METHODS

The primary qualitative method selected for this study is in-depth interviewing, which involves repeated face-to-face encounters between the researcher and informants (Taylor & Bogdan, 1998). Repeated contacts help the researcher establish rapport with informants and get to know them well enough to understand the meaning of their words. I used face-to-face interviews and field notes. To assist in the data collection phase, I utilized field notes providing a detailed record of the informant's behaviors during various meetings. I explored topics that may be uncomfortable for informants to discuss. Moreover, with the in-treatment subsample (described below), I observed ingroup sessions and, thus, will describe group interactions and nonverbal behavior and interpret the transcripts and tape recordings.

Using relevant open-ended questions, in-depth interviews elicit informants' perspectives on their own lives, experiences, and situations, expressed in their own words. Specifically, the interviews elucidate how informants identify themselves, what they perceive as the major events and turning points of their

lives, and how they understand their own insecurities, problems, and fears. In short, in-depth interviews reveal how individual informants make sense of their lives and their world.

### **3.2. Study Design.**

A three-group comparison design was employed for the study. The purpose of subgroup comparisons is largely descriptive, but the element of comparison with respect to some characteristic is added. In this instance, the comparative aspect explores if, and how, the experiences and perceptions of substance-dependent women who overcome the barriers to treatment and seek help differ from the experiences and perceptions of those who do not. Substance dependency is defined as addiction to any legal (alcohol, prescription drugs) or illicit (pot, cocaine) drug.

A total of 30 women was interviewed: 10 women who are inpatients in a treatment facility comprises of one subgroup; 10 women who are in recovery and attended an aftercare program comprises of a second subgroup; and 10 women who are not in treatment comprises the third subgroup. All subjects are 18 years old or older and, thus, of legal age to provide informed consent. Names of the participants are replaced with numeric identifiers to ensure confidentiality. The interview guide is lengthy and each interview entailed one sessions, each lasting

approximately 1½ hours. A period of approximately six months was used to complete this phase of the research.

Rather than a formal structured questionnaire, an interview guide (attached) was used that employs open-ended questions meant to elucidate the salient issues of the study: the barriers to treatment and recovery that are experienced by women with problems of substance abuse and ways these barriers may be overcome. Perceived barriers to seeking treatment; details and perceptions of the substance abuse itself and the experiences surrounding it; the events, for the in-treatment and aftercare subgroups, leading up to their entry into treatment; perceptions regarding the importance and effectiveness of gender-sensitive programs; and perceptions of their current situations and problems are among the specific types of information the interview guide elicited.

The interview guide is not meant to be a structured schedule or protocol. Its purpose is to remind the interviewer to ask about all the relevant issues. The first part of the guide contains general questions that are used to 'break the ice' and to provide an overall picture of the individual woman being interviewed. The second part of the guide contains those questions, drawn from the literature, that are specific to barriers to treatment and how, for the in-treatment and aftercare subgroups, they were overcome. This section also

includes questions regarding the present circumstances and experiences of each woman. The demographic questions in the third section provide an index for measurement of the intersecting variables of gender, race, and class as they pertain to barriers and overcoming them. Any further questions asked of individual participants depended on the answers they gave to the questions in the guide. This flexibility in questioning enabled participants to elaborate on their own unique experiences and allowed the researcher to capture the complexities of each individual informant's history and point of view.

The interview guide was pretested on several substance-abusing women in treatment who were not be subjects of the study and who did not come from the same treatment facility as study participants. The pretesting provided an opportunity to determine how well the questions elicited the kinds of information being sought and to fine-tune the questions before they are used with study subjects.

The interviews were conducted orally in a setting where there were unlikely to be interruptions and informants can feel relaxed. The in-treatment subgroup interviews took place within the treatment facility; locations for the nontreatment and aftercare subgroups' interviews were chosen by the subjects, their homes or some public place in which they would feel

comfortable. All the interviews were audiotaped. Tape recording allows the researcher to capture more of what respondents say and how they say it than would memory or note taking alone. Although the presence of a running tape recorder may alter what some people say, most people quickly forget about the recorder and speak more freely (Taylor and Bogdan, 1998). Nonetheless, the presence of the tape recorder was minimized by placing it out of sight, and the microphone selected was sensitive enough to pick up voices without requiring informants to speak directly into it.

### **3.3. Sampling.**

Theoretical sampling (Glaser & Strauss, 1967) was used to determine which women to include in the study. In this approach, the researcher consciously selects additional informants to be interviewed according to the potential they offer for developing new insights or refining insights already developed (Taylor and Bogdan, 1998). The goal of the sampling is to maximize variation in additional cases in ways that may affect the important variables under study and help determine how generalizable the results are (Glaser & Strauss, 1967). In this research, theoretical sampling was utilized to include women of different racial or ethnic minority groups and socioeconomic classes in order to shed light on variability in barriers to treatment and

recovery. Sampling for the in-treatment group occurred first and continued until the racial/ethnic composition approximated group percentages held in the Austin area: white, 53%; Hispanic, 31%; black, 10% (Austin City Connection, 2003). Further, this sample was drawn to maximize social class diversity. The pretest group was also selected by this strategy. The subsequent sampling of the nontreatment and aftercare subgroups continued until the 10 women in each corresponded to the demographic characteristics of the in-treatment group.

Informants for the in-treatment subgroup were recruited from all women residing in a substance abuse treatment facility (described below) through the posting of flyers and bulletins at the facility after receiving permission to do so. Respondents were selected using the race/ethnic/class sampling criteria. As previously discussed, women in treatment have been successful in overcoming barriers to treatment. As a result, whatever is learned from their experiences is likely to be informative and useful for other substance-abusing women, as well as for policy makers and program developers. The fact that the women have overcome the barriers is likely to make them more aware of the barriers and better able to verbalize their experiences. Similar arguments in support of using informants who have successfully obtained treatment have been made by several other researchers

(e.g., Bowser and Bilal, 2001; Chermack et al., 2000; Gomberg, 1986).

It is advantageous to study women in residential treatment programs for a number of reasons. Women in such programs have started to gain perspective on their problems away from the influence of alcohol or drugs and the socioeconomic environment that contributed to their substance abuse. Also, when informants are drawn from a population in a residential program, there is likely to be less attrition from the study for follow-up interviews. In addition, in-patient populations are more convenient to study, which reduces the time and cost of the research.

Informants for the aftercare group were 'graduates' of the same program currently attended by the in-treatment group and who continue to access the facility's aftercare program. Sample recruitment, as with the in-treatment group, occurred through the posting of on-site flyers and bulletins. This aftercare program offers continuing support, counseling, and employment training for a period of one year to women who have completed the treatment program. This subgroup was selected along the race/ethnic/class criteria, as well as a time parameter. The women must have completed the program at least three months prior to participation in the study.

The data from this group illuminate the degree to which, and how, overcoming the barriers is solidified in recovery as the women transition back into the mainstream. This captures the experiences and perceptions of women in various stages of recovery, their perceptions of the treatment program, how they currently deal with their addiction, and how these may vary by race, class, social support, or other relevant factors.

Informants for the nontreatment group also were selected on the race/ethnic/class criteria. They were recruited by the posting of flyers and bulletins announcing the study. Flyers were placed in a variety of pertinent locations, both discreet and prominent, after permission was obtained from the appropriate authorities. These included the women's bathrooms and bulletin boards of medical (private and public clinics and hospitals) and mental health and social service facilities, police stations, women's shelters, emergency rooms, Al-anon meeting places, and the university. Respondents recruited for the study were asked, at the end of their interview, if they knew of anyone who might be interested in participating in the study, thus generating snowball sampling.

The nontreatment subgroup included women who have never sought treatment or who have entered treatment once but did not complete the program and whose sobriety continued for no more than three months. The data derived from the nontreatment

subgroup brought to the study insights into the personal and social factors that deter substance-dependent women who need treatment from seeking it or successfully completing a treatment program. Identifying and assessing these issues is an important aspect of lowering the barriers for women.

#### **3.4. Recording Field Notes.**

This researcher maintained a field diary to chronicle personal feelings, thoughts, perceptions, hunches, and questions for further inquiry, as they arose throughout the research process. This was part of the ongoing process of data analysis, as well as a way to track research tasks and record additional information, such as conversations with informants beyond the interview situation.

Field notes also were recorded during interviews for several important purposes (Fontana & Frey, 1994). They contained an outline of topics discussed in each interview, making it easier to keep track of what had been covered and what should be followed up. They were also used to make note of emerging themes and interpretations, and to record nonverbal clues to meaning, such as facial expressions and gestures. The notes of interviews assisted in guiding future interviews and analyzing the data later.

### 3.5. Analyzing Data.

The audiotapes of the in-depth interviews were transcribed to provide a written record of each interview for data analysis. Data analysis itself was an ongoing process, in which the researcher constantly tried to make sense of the data. In this process, ideas that developed in reading through and thinking about the interview transcripts and field notes were added to the notes as they occur.

The overall goal of data analysis in qualitative research is to arrive at a good fit between the data and explanations of social phenomena (Taylor and Bogdan, 1998). In terms of the proposed research, the aim is to fit women's perceptions of barriers to general ideas about the barriers that inhibit treatment. Specific steps toward this end can be summarized as follows (Denzin, 1978; Katz, 1983; Taylor and Bogdan, 1998):

1. Develop a working definition of the phenomena under study (e.g., the barriers to treatment).
2. Formulate hypotheses to explain the phenomena (e.g., lack of child care is the primary barrier women with young children face in entering substance abuse treatment).
3. Study one case to examine the fit between the case and the hypotheses.

4. If the hypotheses do not fit the case, reformulate the hypotheses or redefine the phenomena.
5. Actively search for negative cases to disprove the hypotheses.
6. When negative cases are encountered, repeat step 4.
7. Proceed until the hypotheses have been adequately tested, that is, until a good fit between the data and the hypotheses has been attained.

A fundamental aspect of qualitative data analysis is data coding, which is a way of developing and refining interpretations of the data (Taylor and Bogdan, 1998). Data coding involves bringing together and analyzing all the data bearing on particular themes, ideas, and concepts by assigning each piece of written evidence a symbol or number to reflect the category or categories in which it belongs. The number of coding categories used depends on the amount of data and the complexity of the analysis. Typically, the coding scheme is refined as the analysis proceeds.

Coding and other tasks of data management were facilitated by use of the Non-numerical, Unstructured Data Indexing, Searching, and Theorizing (NUD-IST) qualitative data analysis software program. Features of NUD-IST are coding, memoing, search and retrieval, data linking, data display, flexible

graphics, editing, and conceptual theory building (Richards & Richards, 1994).

NUD-IST has two components for managing documents and ideas. The first component is a document system that holds textual level data about the documents. The documents were indexed by codes, and retrievals were grouped into qualitative matrices. The second component is an index system designed to allow the researcher to create and manipulate concepts and store and explore ideas. The indexing is in nodes that allows for hierarchical organization of the data. This hierarchical arrangement represents the organization of concepts into categories. A documented history was saved for each node and aided the researcher in tracing the process of organizing the data. NUD-IST assisted the investigator with qualitative analysis of the data and supported the development and testing of new ideas without the risk of losing complexity and context.

The NUD-IST program assisted with the identification of emergent themes, and the construction of coding categories. This process began by reading printed copies of the transcripts. The transcripts were freely coded via computer and used the free nodes for all of my initial codes. The initial codes were based on each interview element (i.e. one question and answer). The interview element became an unit of analysis for which the initial code was developed. In reviewing the first five

transcripts, more 157 codes were developed. These codes were merged by hand. I printed out a copy of the codes, enlarged a copy of the codes as a visual aid, and printed this copy. I then cut out the codes and grouped them into categories. After coding all the interviews, I used the questions guiding this study to explore the data and identify relevant themes. The themes were role of mother, social stigma, abuse, and victimization and social support.

### **3.6. Study Site, In-treatment and Aftercare Subgroups.**

The site that was selected for sampling the in-treatment and aftercare subgroups is Austin Recovery, a residential substance abuse treatment facility located in Austin, Texas. Austin Recovery is a nonprofit therapeutic community that was founded in 1967. It offers clinically managed, very intensive substance abuse treatment, 24 hours a day, 365 days a year.

In 1982, Austin Recovery began providing services specifically for women. Since its expansion to accommodate women, Austin Recovery has made women's issues a central feature of its service package. The facility was purposely chosen for this study as an example of a treatment program designed to incorporate the specific needs and issues of addicted women indicated in preliminary research. The existing literature suggests, for example, that a primary issue pertinent to

substance-dependent women seeking treatment is the lack of child care alternatives and the fear of child custody loss (Allen, 1995; Carter, 1997; Cohen, 2000). Austin Recovery addresses this by providing residential facilities for up to 25 women and their children for duration of six to nine months.

The holistic program offered at Austin Recovery takes into consideration many of the barriers to treatment and recovery faced by substance-dependent women proposed in the research. In addition to child care provisions, "Mothers' Workshops" are held to help participants ease the shame and guilt that accompany the effect their addictions may have on their children (Cohen, 2000). Further, rather than treating the addiction as the sole or primary problem, as men's treatment programs typically do, the Austin program acknowledges the unique treatment needs of women dually diagnosed with addictions and psychiatric issues such as depression. The program attempts to strengthen self-perceptions and self-empowerment skills through interventions, group workshops, and interactions designed to promote a healthy self-image and accountability for recovery, and to allow each woman to de-stigmatize her illness.

The signature feature of treatment at Austin Recovery is the use of the peer community to facilitate social and psychological change in individuals, under the guidance and supervision of experienced, trained staff who are familiar with

all aspects of the treatment process. The involvement with similar others is expected to join each substance-dependent woman to a group perspective constructed from each individual's experiences. This group membership may offer the individual the social support necessary to foster and encourage a new identity and sobriety goals. Each participant also attends a daily 12-Step Meeting conducted outside the facility, which may not only enhance the possibility of connecting to a wider network of people who share similar experiences, problems, and goals, but also maintain some level of community engagement.

Research findings suggest that the lack of social support from significant others impacts the onset and progression of and recovery from addiction in women (Zelvin, 1999; Miller, 1998; Bischoff et al., 2000). Austin Recovery attends to this by offering family workshops that foster insights into codependency and help significant others to understand the addiction process, the effects of the addiction on the entire family, and how relational support promotes successful recovery. Families are encouraged to learn healthy models of interaction as they work towards resolving past issues and creating fulfilling relationships.

Austin Recovery tackles substance abuse, in part, as a disorder of the whole person, so the goal is to elicit a global change in the individual's lifestyle, as opposed to the

cessation of substance abuse alone. The women are counseled in identifying, examining, and restructuring self-defeating thought and behavior patterns, especially those that lead to relapse, and they study and practice techniques for interrupting relapse cycles. The treatment program also emphasizes the relational, interactional, and family-based aspects of addiction and recovery that research shows are essential to treating substance-dependent women.

Austin Recovery offers to its residents education and vocational training for the development of the interpersonal and life skills that are needed to remain substance-free after they leave the program. They also are provided with information and skills for networking with resources in the community to expand their recovery options after treatment. Women who have completed the treatment program can attend a year-long aftercare program that continues the emphasis on education and vocational training, and interpersonal, life, and networking skills to promote sobriety.

Given the barriers proposed in the literature and the woman-centered program at Austin Recovery, the women who receive treatment there may develop valuable insights into their substance abuse problems and the barriers that inhibit treatment. Whether the women seeking treatment at Austin Recovery knew of the potential advantages offered by the program

prior to entering treatment and the degree to which they perceived the program as lowering the barriers to treatment is explored through the interview.

### **3.7. Significance of the Study**

This study is significant because its focus is the connection between social processes and their outcomes and its approach encompasses all the linkages between micro and macro levels of activity. The study therefore provides a useful tool for examining the linkages among policy initiation, formulation, and implementation across levels. Specifically, the study provides insights into the powerful psychosocial and structural forces that affect barriers to treatment, the ways in which women can act to resist the barriers or alter their meaning and thereby overcome them, and a possible treatment model that highlights their specific needs.

### **3.8. Ethical Considerations**

Prior to the recruitment of any subjects, whether those in the pretest group or the study subsamples, I obtained the approval of the IRB to conduct the study. The board was fully informed of the study procedures, informed consent process, and all potential risks and benefits to the subjects. After obtaining IRB approval, the sampling began. All participants are at least

18 years old and thus of age to signed informed consent. No woman was interviewed until she has signed a written informed consent. The consent forms included information regarding the nature and description of the study, risks and benefits to participants, their right to voluntarily withdraw from the study at any time, and the manner in which their right to privacy would be protected.

## **4. CHAPTER IV**

### **4.1. DESCRIPTION OF DATA**

This study sought to enhance understanding of substance-dependent women's barriers to treatment and to do so from the perspectives of the women themselves. The few empirical studies centering on this issue have indicated that substance-dependent women may confront different challenges and barriers than those confronted by substance-dependent men; however, the methodologies used rarely draw out the subjective experiences of women as they relate to the barriers. This study overcame this difficulty by collecting data through a qualitative approach utilizing both in-depth interviewing and participant observation.

### **4.2. Descriptive Profiles of the Interviewees**

A total of 30 women were interviewed, equally divided among the three comparative groups: aftercare, inpatient, and nontreatment. Descriptive profiles derived from the interviews are broken down

below by group. The complete demographic information is synthesized in Table 1.

#### **4.3. Aftercare group.**

The ages of the ten women in this group ranged from 20 to 60+. Forty percent of the participants fell within the 31 to 40 years age grouping. One half of the women (50%) had a high school education or less, and the overwhelming majority (80%) reported \$20,000 or less in annual income. Sixty percent of the women self-reported as Hispanic. All of the women in the aftercare group had children, from one to six, whose ages ranged from less than one year to over 18 years.

#### **4.4. Inpatient group.**

The ages of the ten women in this group spanned 20 to 50 years; one-half (50%) were 30 or under. Seventy percent reported nine or fewer years of formal education, and none of the women had an annual income exceeding \$15,000. Here, too, one-half (50%) self-reported as Hispanic. All were mothers of from one to five children, although the children's ages were somewhat younger, or less than one year to 12 years, than those of the children of the women in the aftercare group.

#### **4.5. Nontreatment group.**

Ninety percent of these women were 40 years of age or younger, and half (50%) were under the age of 30. All of these participants

had 12 years or less of formal education, which was reflected in their incomes: 60% reported annual incomes of \$5,000 or less. This group was the most racially/ethnically diverse: 40% self-reported as Hispanic, 30% as white, and 30% as black. As in the two previous groups, all the women had children, from one to five, whose ages ranged from less than a year to over 18 years.

**Table 1 Demographic Profile of the Sample**

	Aftercare Group	Inpatient Group	Nontreatment Group
<b>Age</b>			
20-30	3	5	5
31-40	4	3	4
41-50	2	2	1
51-60+	1	0	0
<b>Years of Education</b>			
6-9 YRS	5	7	8
10-12 YRS	3	2	2
13-16 YRS	0	1	0
16+ YRS	2	0	0
<b>Income</b>			
\$0-5K	1	7	6
\$6-9K	2	2	1
\$10-15K	1	1	1
\$16-20K	4	0	1
\$21-30K	1	0	1
\$31-50K	1	0	0
<b>Race</b>			
White	3	3	3
Black	1	2	3
Hispanic	6	5	4
<b>Number of Children</b>			
1	3	1	4
2	2	1	0
3	1	4	3
4	2	3	2
5	1	1	1
6	1	0	0
<b>Ages of Children</b>			
0-1YR	1	5	1
2-4YR	2	3	2
5-8YR	2	1	5
9-12YR	2	1	1
13-17YR	1	0	0
18YR+	2	0	1

#### **4.6. Participant Observation**

As noted in the methods section, the researcher spent twenty weeks at the Austin Recovery Treatment facility to immerse myself, initially as an observer then as a participant, in the culture of the treatment program and learn the behavioral patterns, beliefs, and expectations of the women in the aftercare and inpatient programs. By participating in routine activities, such as meals, breaks, and educational sessions, the researcher was able to establish that her presence was non-threatening and non-judgmental. This allowed her to build rapport with the women.

The aftercare and inpatient groups displayed a different kind of dynamic, in comparison to the nontreatment group. The relationship with the aftercare and inpatient group was very personable and formal. Relationship with the nontreatment group was very informal and only lasted as long as I interviewed the women. The relationship with the two groups focused on attempts to construct an identity as a participant observer/researcher. It was interesting not to make the women feel uncomfortable as a researcher and at the same time not compromise data collection by neglecting to record my observations. Many times while recording the data, the researcher had to be cognizant of remembering to record the data.

While observing the aftercare group, it was interesting to see how the women's attitudes and behaviors towards the facilitator, Sally emerged. Sally was also a counselor on the staff, involved with most of the women weekly on a one-on-one basis. She was very familiar with the women therefore, most of the information that the women would share with the group, Sally knew in advance. Sally would often challenge the women on behavior that was compromising and detrimental. On one occasion during the group, one of the women admitted to drinking while she and a friend went dancing. Sally was very direct and confronting about the woman's decision to visit the club. She then reminded the woman about being aware of her surroundings, in order to avoid relapse. It was obvious by the expression on the woman's face and her body language that she did not care to receive the reprimand. Sally was also a recovering alcoholic and was very knowledgeable of what the women were experiencing. The researcher noticed on breaks that although some of the women did not like Sally's style or approach, she was highly respected.

On one occasion while talking with one of the women during a smoke break; she began to inquire about my personal life. She was interested in knowing if I had any children and how I was able to work a job and cope with everyday stresses of work and children. I informed her that I had two sons, and that although it is difficult to juggle the boys' sports activities and other activities, I rely

on community support to assist me with many commitments. She admitted that although her children were grown, she did not take advantage of community support and most of her stress was due to her not being able to properly raise her children and work. She admitted that she does not have a bond with her children due to loving her drug more than her children. Another woman, who appeared to take a liking to me at the onset, would always greet me with "hey lady". She would always ask how my day was and tell me about her day. She was very popular with the other women and I felt that this really gave me some needed "points" with some of the women. I enjoyed my discussions with her.

#### **4.7. Aftercare group.**

The aftercare group consisted of women who had graduated from the Austin Recovery Treatment facility following three months of treatment. The women agreed to a contract to continue in aftercare treatment for an additional three months.

Every week, the two-hour aftercare group meeting, which approximately 25 women attended, began with the facilitator playing a relaxing musical tape for deep breathing exercises. The women then introduced themselves by first name only and as addicts or alcoholics. The group facilitator would then lecture on different topics for the week. During my weeks there, the topics included post-acute withdrawal symptoms, grief and loss,

sexuality, integrative breath work, the importance of exercise and a healthy diet, relapse prevention, the dynamics of self-esteem and self-worth, and dealing with emotions.

These lectures were followed by a break; then, the meeting resumed with the facilitator's asking if anyone had anything to process for the week. Invariably, one or more of the women did.

On one occasion, one of the women volunteered to process her week. She informed that group that she had been struggling with returning to her boyfriend. Her boyfriend was also addicted to drugs, and was the one that introduced her to cocaine. She stated that he is currently receiving treatment, but does not know how serious he is about becoming clean. She admitted that she met him one night and the intentions of meeting each other was to talk about their future. She stated that although he told her he was receiving treatment, he convinced her that it was harmless to drink beer. She admitted that she knew it was wrong, but indulged with him. She also admitted to the group that she felt guilty and understands that she has to begin her process over again. The group began to ask her questions about how she could have prevented drinking the beer. If she really feels that her boyfriend would be good for her.

It was during these processing sessions that much was learned about the women's backgrounds and their experiences as they related to their addictions.

They came from all walks of life, such as prostitution, nursing, and accountancy. Some of the women resided with relatives; others stayed in a halfway house or found jobs that enabled them to acquire a place of their own. Many women spoke of their victimization by significant others, the difficulties connected to or exacerbated by having children, depression, and problems in seeking or staying in treatment.

#### **4.8. Inpatient group.**

The researcher's acclimation to the program and its agency rules were extremely important, since many of the women entering the program not only reported feelings of low self-esteem and self-worth, but also lack of trust. The women were sensitive to any kinds of differences that were shown to them by staff members or by the other women. They complained of feeling hurt when another program participant refused to help them or watch their children.

Care was taken to interact with all of the women in order to be accepted and establish the rapport that was so important for the study. The researcher assisted the women in daily activities. One of the teenage mothers whom I assisted with cleaning her living space had a difficult time knowing how to arrange her belongings. She confessed that she was the baby of her family and was never required to clean her room or perform

any chores around the house. She stated that her parents and sibling mostly catered to her. She also noted that since she has a young child, it was difficult to organize or prioritize her household chores. She indicated frustration with being a parent and allows other people to keep her child.

Other women were also challenged and the researcher helped them with such duties as washing dishes and watching the children to provide these mothers with a little down time for themselves. Residents watching other resident's children posed no problem, nor was there a trust issue involved due to the facility being surrounded by full-time staff members on a twenty-four hour basis.

Many of the women entered the program in a state of disarray, compelled by external expectations of drug court or child protective services. Initially, the women and the children who accompanied them spent significant time completing psychological and physical assessments. The women also enrolled in public assistance programs.

A three-layered accountability structure operated at the facility. The top layer comprised the clinical staff, which included the program director, a psychologist, a substance abuse counselor, a case manager, a nutritionist/case manager, and a nurse. The clinical staff was responsible for developing and implementing the treatment plans for the women and, when

relevant, reporting to the authorities on the women's progress. The second layer included the child development specialist, childcare workers, and staff technicians who were responsible for assisting with childcare and monitoring the women's compliance with the rules. The third layer consisted of resident representatives. As a woman approached completion of the program, she served as the resident representative and was accountable for leading and planning activities and monitoring her peers' compliance with the rules.

New residents were responsible for learning and obeying the program rules that applied to them and their children. Most of the "experienced" residents helped to create a supportive and challenging environment. The "experienced" residents, while understanding how the new residents may have felt entering into the program, became counselors to them. The new residents appeared to feel welcomed by them. Each new resident was assigned a partner to familiarize her with the program, escort her to appointments, and inform her about daily program activities and her responsibilities. Although some of the women were diligent in this duty, others treated it as a burden and neglected to inform the new women of their responsibilities. Some of the women had a difficult time complying with the facilities rules and regulations, which was not surprising since some came from backgrounds with no supervision. One woman had a

difficult time concentrating while she was in one of the group meeting. She became very frustrated with being "caged up", as she would describe it, and began shouting at the facilitator and those surrounding her. She was quietly escorted from the room and the facilitator was able to describe to the rest of the participants the women's stage of recovery.

Group meetings during the weekday were scheduled and directed by either the program staff or personnel from community agencies, such as the parent education organization or violence against women association. Even though the staff chose the topics, they encouraged input from the residents. During the researcher's time at the facility, these included parenting classes, healing relationships, relapse prevention, anger management, child development, family relationships, alcohol and narcotics anonymous, breathworks, and individual and group counseling. Residents were accountable for timely attendance, group participation, and their conduct in the groups. All of the women were encouraged to express themselves, although the newer residents tended to focus on issues outside the program, such as financial and familial issues, maintaining housing, or securing jobs, or to follow the lead of other residents. When the residents focused on outside influences of the program, the facilitator quickly redirected their conversation to issues of recovery.

Some of the recovery groups had a ritualistic format that the women adhered to during their stay. One group, for example, began with the residents entering a large meeting room and rearranging the chairs to form a circle. After the women were seated, they did not speak until the staff member indicated that the meeting had begun. Group sessions began with one of the women reading the program's philosophy, another reading the rules of the group, and the resident representative giving a report on the cleanliness of each woman's room. For the conclusion of the group meeting, which staff always initiated, residents and staff huddled in a circle with their arms on each other's shoulders. In unison the group said a prayer, hugged everyone individually, and the residents then returned the room's chairs and table to their original positions.

## 5. CHAPTER V

### 5.1. BARRIERS TO TREATMENT

This chapter will explore what we can learn about barriers to treatment and how the barriers may be overcome by understanding viewpoints of substance-dependent women who have overcome the barriers and those who have not. The literature concerning the barriers to treatment for substance abuse issues suggests that women face greater barriers than men do; barriers that are not only gender-specific, but that are also comprised of an interdependent set of factors such as socioeconomic status and a lack of social support (e.g. Beckman & Amaro, 1996). Further, low self-esteem and other negative self-perceptions that lead to addicted women's denial that they have substance abuse issues (e.g., Thom, 1986; Wilson & Anderson, 1997), are posited as the reasons why women do not seek treatment in the same proportions as do men. However, substance-abuse literature on women is not only limited, but also largely quantitative and based upon studies that are designed from a masculine perspective. Therefore, it is difficult to say how women perceive those barriers. This study examined how women perceive obstacles to treatment as the barriers. Particularly, those

barriers in which these women have overcome, and how the women managed to overcome them.

The findings of this study refute the theory that denial is a primary barrier to treatment. Most of the women, after a six- to twelve-month period following the onset of heavy use, realized that they had a problem with substance abuse. In addition, they reported that they continued to use despite of this knowledge, which does not follow the definition for the coping mechanism of denial. (For an action to be classified as denial, it must take place outside of one's conscious awareness. For denial to be a factor in play for these women, they would have had to truly have no awareness that they had a problem, as opposed to continuing their substance abusing behaviors in full knowledge of -- in despite of -- that fact.)

One of the most frequent reasons given by the women in this study for continuing to use (despite knowing they had problems with substance abuse) was the fact that their addictions made them feel better about themselves and their lives. They reported that their substances of choice alleviated their symptoms of depression and enabled them to feel as if they were more in control of their lives as well as increasingly able to cope with the problems that they faced. This finding aligns, in part, with the work of Gomberg (1986) and Helzer and Pryzbek (1988), who assert that depression and an accompanying inability to cope

with life is the primary problem (and therefore primary barrier to treatment), while substance abuse is secondary. They found that for as many as 67 percent of women, depression is the primary challenge and substance abuse is the second. The following are representative responses from interviews that supports this observation:

NONTRT- I have a big problem with being depressed. I would self-medicate by drinking booze. I could not control my drinking and was given an option by the courts to go to jail or get into treatment. I tried to get into a treatment program before, but did not have the money or insurance to do so. I also found out that the program had kids staying with them. This was a big help. So I chose to get into the program. I could not do so if I did not get arrested.

INPT- I knew as a little girl having problems concentrating and not being able to control my temper. My mother would tell me that I did not want to obey her rules and would be happy one day and depressed another. I found myself taking aspirins as a teenager to try to make myself happy. This was the beginning of how I would try to make myself happy. If aspirin would not to the trick, I would sneak into my mother's liquor, then I experience drugs with friend and my

drug habit became stronger and stronger to try to stay upbeat.

This brings into question a variety of further issues that need to be considered. First, dual-diagnosis presents diagnostic and treatment-related challenges, if only because there is often (either explicitly or implicitly) an emphasis on prioritizing the diagnoses. In other words, there is critical importance placed upon which diagnosis is the "primary" one. While this perspective makes sense in the context of treatment that focus on one or the other diagnosis, however it does not fit well with the general population of substance-abusing women who also struggle with clinical depression.

The issue becomes one of the chicken and the egg, to the detriment of these women who need assertive treatment for both issues. Are they self-medicating? Perhaps. Once they receive proper treatment for their psychological distress, will the substance abuse issues disappear? Probably not. This suggests that an integrated approach designed to work with both psychological and addictions-based problems at the same time might work better with women. This possibility is borne out by the words of the women in this study, who over and over again point to psychological distress (often brought on by past or on-going experiences of trauma) in combination with a compulsion to

use even when that use is admittedly counterproductive (e.g. to keeping custody of one's children).

Second, by segmenting the issues of substance abusers into separate diagnoses, treatment providers box themselves into a segmented approach to treatment as opposed to an integrated approach to healing. In other words, by refusing a client-centered approach that sees people as the sum total of their strengths and weaknesses, all of which both support and inhibit the others, treatment providers ignore a more holistic approach that could prove to be more successful, particularly with women.

Instead of seeing depression as a barrier to treatment, it might be more instructive to shift the focus to the lack of treatment programs that address the interaction of depressive symptoms with substance abuse. In other words, it is conceivable that depression is not a barrier to treatment, but rather that depression conceals from the provider how to effectively treat the person. Perhaps the presence of depression (and, one can infer, other psychological diagnoses such as post-traumatic stress disorder) is in itself no barrier to treatment, but rather that it is the lack of a cohesive treatment response to dually-diagnosed women that is a barrier to effective treatment.

The other most commonly-stated barrier to treatment -- one that is both well-documented in the research and also reflected in the findings of this study -- is that of losing custody of

one's child/ren (e.g. Allen, 1995; Carter, 1997; Cohen, 2000; & Copeland, 1997). Consider these words from several of the women:

INPT- At first I thought that comin' into a program meant losing everything. My children was very important to me. When this program said they had childcare arrangements, I had to go into treatment, so I was glad they had this program.

AFTC- I knew after two driving while intoxicated charges, I knew I had to go into treatment program. I had no insurance, no money to get into treatment. I had three small children. I burnt all my bridges with my family and friends and could not ask them for anything. So I thought I should give my kids up to child protective services temporarily, but it was hard to do for the three months that I stayed at the program.

NONTRT- I consider myself as a social user. I only use after work and on weekends. I don't feel I need to go to a program because I can control myself. I don't think I could go to a program if I ever needed to, because they are so expensive and I don't have insurance to go to a program. I

also have kids, and I know programs will not be able to keep your kids.

NONTRT- My family has hounded me to seek some help. I work everyday and cannot afford to miss work or go to a program. I have heard that the program helps but I cannot afford to leave my kids as well. My family have not offered to keep them. So I don't know what exactly to do.

Those women who are able to overcome this barrier generally have help either from their families or else from the treatment program itself. Note that, in the case of the second woman, although she was able to overcome the barrier of not having anyone trustworthy to care for her children, she remains addicted after a ninety-day treatment program. Clearly, there are other barriers here that have not been addressed.

NONTRT- I knew I had a problem when my drug habit increased to \$100.00 a day. I began prostitution for drugs. My sister found me on the streets one day. My parents paid for me to go to this treatment facility. My family supported me with keeping my children.

NONTRT- I've been in treatment one time before. I completed the program and relapsed. The drug keeps callin' me. I went

into treatment because the courts said I had a problem. I had kids at the time, but my family kept them while I went to a 90-day treatment program. I went back out into the streets and kept using. I have not seen my kids in years.

A lack of social support -- either directly or indirectly - was another stated obstacle to treatment. This correlates with the research (e.g. Carter, 1997; Cohen, 2000; Copeland, 1997; Gomberg, 1988; Schober & Annis, 1996) which suggests that women perceive a greater sense of stigma associated with their addiction than do men. Consider these responses.

AFTC- I knew trying to get into a treatment program, people would see me as an outcast or somethin'. I knew people in the welfare office that I would go to looked at me like I was a disease. I thought that having a problem with drugs no one would want to help me. So I just started using drugs more. I knew I needed help but I thought no one would help me, but just label me as a misfit.

INPT- My family saw that I had a problem when I started drinking at age 14. But when I got older, I started using harder drugs to get higher. I knew I needed help, but getting into a program did not cross my mind. I thought I could just stop. But the problem became worse. So after

spending time in jail, I was placed in a treatment program. This is my second program. I had no problem getting in, my problem is staying clean.

The first woman is worried about what people would think about her if she sought treatment (interestingly, she is not worried about what they think of her as a person with an active addiction). The second woman does not come out and say that she has no support with her substance abuse problem, but she does state "my family saw that I had a problem when I started drinking at age 14." They apparently did nothing to intervene at the time, in part evidenced by the fact that "getting into a treatment program did not cross my mind."

Conversely, social supports were critical for those women who overcame their stated obstacles to treatment (to be examined more thoroughly in the next chapter). Among those women, there was a general consensus that they did so primarily because they were subjected to external pressures that essentially forced their hands. Either a significant other (such as a parent) made it clear that they had to seek treatment for their substance abuse problem, or else a legal entity (most usually a judge) mandated attendance in a treatment program, usually as a condition for resuming custody of their children. Occasionally, workers in social service agencies brought pressure to bear on

the women and motivated them to seek treatment despite whatever obstacles existed.

Consider the following representative words from the two groups of women who are receiving treatment:

AFTC- My family was very concerned about my addiction to cocaine. I did not realize that they knew I was using. When I would visit my family, I would notice them talking behind my back. My mother and sister would tell me that I seem distance with family members and with my children. They said that I seemed very nonchalant about various things that I cared about. About a few weeks later, I was arrested for driving while under the influence. I agreed to seek treatment at the advice of the courts.

INPT - I had gotten in trouble with the law. I was arrested for fighting another girl. She dissed me. I don't like no one dissing me. I was arrested for simple assault. I had a few beers that day and smoked a joint. When the courts sentenced me to treatment, I told them I had nobody to take care of my kids. That's when I found out about this place. It is good that I am able to keep my kids with me throughout this place. I still don't think I have a problem; the girl should not have made me mad.

Many of those in the both the aftercare and the inpatient groups were in this same situation. They were forced into treatment by the judicial system after either one incident or a history of criminal activity. However, again, it can be instructive to read between the lines, if only to raise more relevant areas of inquiry. First, the laws broken by these women are typical of both serious substance abuse issues (as in the first woman above, who was arrested for driving while under the influence) and psychological issues (as in the second woman, who was arrested for fighting another girl who had "dissed" her, indicating an anger management problem possibly stemming from depression and/or serious issues with self-concept). It would be interesting to investigate the similarities and differences between the criminal behaviors and subsequent sentences of men and women with substance abuse issues to answer such questions as the following: Do women tend to be mandated to treatment more or less frequently than men? Are they mandated to treatment after fewer, more, or the same number of criminal infractions? When women are so mandated, what are the contingencies resting upon their mandated treatment that prove to be the biggest motivators for compliance? The answers to these questions would provide much feedback for, among other people, law enforcement and justice officials who wish to use treatment as a sentence

for women who break the law at least in part due to their substance abuse issues.

Second, it is interesting to note that the inpatient woman above might seem to be an example of someone who is in denial about her substance abuse issues. She states that "I still don't think I have a problem, the girl should not have made me mad," and notes that she had a "few beers" and smoked a joint. Is this an example of a woman whose "primary" diagnosis is, in fact, psychological, and who self-medicates in an effort to mediate the symptoms of that diagnosis? If so, she falls in line with Gomberg (1986) and Helzer and Pryzbek (1988), and, one hopes, is receiving adequate treatment for her psychological diagnosis so that her self-medicating substance use can be phased out entirely. On the other hand, if she does have a "separate" problem with substance abuse, she needs to be helped to acknowledge it if she is to overcome it. Either way, it is highly instructive to hear her words; in part because it calls into question the efficacy of the Austin Recovery Program if she has been there for any length of time, and in part because, again, either way, this woman perceives barriers to her treatment progress.

Consider finally these words from two of the women in the nontreatment group:

NONTRT - I have already been in three programs. I finished one, but didn't finish the last two. My probation officer did not make me, so I didn't finish. I did learn some things from the last program, but this stuff just keep calling my name.

NONTRT- Most of my family is alcoholics and drug users. There was no such thing as treatment. I thought treatment programs were for rich people and people that had big problems. I had treatment about three times that the judge made me go to. All three times I did not finish the program but went to jail to spend out my time. After jail time, I would go back out into the streets. I don't think treatment does anybody any good.

The first woman states that "my probation officer did not make me (finish the last two programs), so I didn't finish." This one sentence brings to light two other possible barriers to treatment: the lack of follow-up on the part of law enforcement officials, and the lack of viable alternatives that speak to all substance abusers. First, this lack of follow-up might indicate a greater need for social supports if women are to be successful in their treatment programs. This issue will be dealt with in greater detail later, but it is interesting that this woman apparently has such an inadequate social support system in her

life that she relied upon her probation officer to continue to pressure her into completing her program. Beyond the implications for women seeking treatment, this piece of information also points to the need, when crafting treatment plans, for significant, on-going sources of support.

This finding is one that is supported by the research. As noted above, the social networks of female substance abusers may generally offer minimal support for recovery and may, in fact, actively discourage sobriety (Beckman & Amaro, 1986; Miller, 1998; Thom, 1986, 1987; Wilsnack & Wilsnack, 1991). Furthermore, many women have friends and family who "brush their problems under the rug" in a misguided effort to protect "vulnerable" women from facing their addiction directly -- or in an effort to hide the problem of a family member of whom they are ashamed or embarrassed. Regardless of the reasons behind a lack of social support, most addicted women seem to have a strong need for it (as do, in fact, many men who more often have spouses and/or others who are actively supportive of their recovery process) -- so much so that the lack of support from a probation officer is seen as a barrier to treatment.

Second, this woman has been in three programs already. This means that either she is still not ready to do the necessary work to overcome her addiction, or there does not exist a program that speaks to her specific needs. It makes sense to

assume that the latter is the case, because the job of treatment providers (and researchers, for that matter) is to cater to the needs of their clients as much as possible. Of course, individuals must be ready and willing to do the necessary work of recovery. However, treatment plans and centers should be as flexible as possible to ensure that the widest range of women can benefit from them. This is beginning to be understood in the context of male substance abusers; it is increasingly recognized that not all men will be helped by Alcoholics Anonymous approach -- or even with any abstinence-based approach at all. This broad understanding should therefore be applied to women. For example, while it appears that many women appreciate programs that are child-friendly, perhaps for some women, the presence of (and discussion about) children in the facility are an unwelcome distraction.

The second woman points to another barrier that will be addressed in more detail in the next chapter, and one that has been shown in the research: a history of familial substance abuse (Chermack et al., 2000). She also points to the class barrier when she says that she thought programs were only for "rich" women -- a barrier that will be examined in more detail in Chapter seven. Finally, this woman has also been in three programs, none of which worked.

In conclusion, this initial examination of the words of the women in this study indicates two main points. First, this study makes it clear that there are barriers to treatment that researchers, treatment providers, and others simply cannot conceptualize because they have not listened directly to the words of the women themselves. For example, perhaps depression in and of itself is not a barrier to treatment, but how treatment providers handle it is a barrier -- if the way it is handled is not conducive to the particular woman in question.

Second, the words of the women indicate that these barriers can be surmounted if the approach can be widened somewhat. For example, if law enforcement officials can be brought into the treatment process for offending women, they can serve as an additional source of support to help the women stick with their treatment plans. The next chapter will explore these and other implications of the words of the women in this study.

## **6. CHAPTER VI**

### **6.1. GENDER-SPECIFIC BARRIERS TO TREATMENT AND RECOVERY**

This chapter will explore what gender-specific barriers to treatment and recovery substance-dependent women identify, both those who have overcome them by their involvement in a treatment program and those deterred from seeking treatment? Cohen (2000), Rasmussen (2000), and Schober and Annis (1996) propose that these gender-specific barriers fall into four general categories: women's role as mothers; the social stigma, negative self-perceptions, and depression that tend to characterize substance-abusing women; their relatively high risk of family abuse and victimization; and their relative lack of social support. Although there is scant research on several of these gender-specific barriers to treatment, the narratives of the women in this study suggest that not only do all of these factors inhibit substance-abusing women from getting the treatment they need, they also intersect in significant ways that further confound treatment-seeking behaviors.

#### **6.2. Women's Role as Mothers**

The lack of child care alternatives and the fear of child custody loss have been proposed as the most pervasive treatment barriers for substance-abusing women (Allen, 1995; Carter, 1997; Cohen, 2000; Copeland, 1997). Since treatment programs are typically based on the needs of men, provisions for child care

are rarely made (Carter, 1997). Findings in this research suggest that a lack of viable child care was, indeed, a factor in inhibiting a majority of these women from seeking treatment. Although more than half of the women interviewed expressed concerns that their addictions negatively affected their children, those concerns were often outweighed by fears of losing their children or not finding an appropriate place for them to stay while they were in treatment.

AFTC - My children are very important to me. I knew the court mandated me for treatment, and had no one to see after my three children. I was very concern about who would keep my children. The program was a three-month program and I did not know who to depend on to keep my children. I had no relatives in town. CPS made contact with me while in jail and told me they would place my children in a foster home. I worried about my children throughout the entire treatment program. I did everything I could do to complete the program and to get my children back.

INPT- I was knocked up and still smokin' the pipe when I was arrested. When the judge told me I needed treatment, they threatened to place my child in CPS custody. I told the judge I would do anything. A month later, I had my other child and was sent to this place. I didn't want my

family to keep my children because I was raped by one of my cousins. I didn't want my girls to be raised in that kind of place.

INPT: The courts told me that they would take my baby if I did not get treatment. I remember having a very low self-esteem when I started living on the streets. I have been having problems craving for cocaine since I have been in the program. I'm hoping I will not relapse because I want to keep my baby. The program helps me understand my drug addiction and cause for low self-esteem. I am also glad that they had parenting classes to help me with my baby.

All of these women were mandated for treatment. The first had no choice about whether or not she could keep her children while in treatment, and so was forced to allow the courts to place her children in foster care for the three months she was in in-patient. The second two women were able to obtain treatment at an inpatient facility that allowed them to take their children with them (the Austin Recovery Treatment Facility). Although they had different outcomes, these women are clear examples of how most women are forced to choose between seeking quality inpatient treatment for their substance abuse issues or finding outpatient help (which, while effective for some women, cannot equal the intensity of therapeutic intervention that inpatient treatment can offer).

It is, impossible to say for sure that the first woman, had she known about a place like Austin that would allow her to take their children, would have entered treatment voluntarily. However, it is also impossible to ignore the information contained in her statement. All of them were afraid of what would happen to their children (the third one from personal experience, as will be seen in a later section), and the first two clearly saw treatment for their own problem as secondary in importance to the well-being of their children. The implication, at least in part, is that inpatient treatment facilities must find ways for women to have custody of their children.

Consider these responses from other women who were fortunate enough to know about a program like Austin that allows them to keep their children with them during treatment:

AFTC- My family and friends kept telling me I needed help, but my kids were very important to me as well. I did not want to leave them. But the threat of going to jail versus going to a program played a big part of going into treatment. When I found out I could keep my kids with me the choice was easy.

AFTC- I went to jail for possession of drugs while I was seven months pregnant. I used drugs while I was pregnant. The judge threatened to take my child after I had her. I wrote a letter to the judge so I could get into a treatment

program. I told the judge I was willing to do anything in order to keep my baby. I was able to keep my baby and go into a program.

INPT- The courts put me in a treatment program. I have two small kids and had no one to keep them. I refused to allow Child Protective Services (CPS) to take my kids. If this treatment program did not have childcare, I think that I would have spent my time in jail and been back on the streets.

INPT- The courts threatened to take my kids if I did not seek treatment. I made attempts to see which of my family members would keep them. The courts gave me 30 days to make arrangements for my kids. Time was running out and one day I heard of this treatment program. I was willing to hide from the courts for my kids. I had never been so stressed.

As noted before, even women enrolled in day treatment programs face problems finding care for their young children while they are attending the programs (Nelson-Zlupko et al., 1996).

It is also important to note that concerns about child care were not evident in all of the participants' responses. For instance:

NONTRT- I want the drug more than I want my kids. I have two kids somewhere in CPS custody and have been on the street for seven years. I tried programs and never finished them. I have been hustling the streets longer than I can remember. I was using the drugs when I was pregnant with my kids. After I had the kids, CPS immediately took them when I was in the hospital. I can't remember if they were boys or girls.

NONTRT- My kids are very important to me. I would kill for my kids. It is hard to stay off the drugs. I knew my kids would be better off with someone that loved them. My kids were all placed in foster care. I loved my kids enough to know that they would have a better life with someone else other than me. I am pregnant now and will give this child to CPS as well.

Change the sex of the first respondent and remove all references to being pregnant, and the statement reads like a rather typical one from a man who has fathered children whom he does not know and continues to abuse substances without regard for them. Society in general -- and treatment providers as well -- views men's disregard for their offspring very differently than it does women's disregard. Perceptions of social stigma are compounded for women who are mothers because of the predominant

cultural attitude that women who abuse alcohol and illicit drugs are "bad mothers" (Cohen, 2000; Colby & Murrell, 1998; Finkelstein, 1994).

Such a gendered perspective has an effect on the treatment of men and women. Consider the general societal outcry against women who abuse substances while pregnant, for example. Although pregnancy may serve as a powerful incentive for some women to seek help for substance abuse, Thom (1986) studies suggest that this desire for help is often countermanded by intense feelings of shame and guilt brought about, at least in part, by the social stigma against pregnant women who abuse substances. It is not necessarily that the women don't care, on their own, that their addictions could be harming the fetuses they carry; in fact, the opposite tends to be the case (Finkelstein, 1994). But in the face of an overwhelming substance abuse problem, when one's own guilt is met with shame-inducing societal condemnations, the overall effect is generally one of shutting down (Miller, 1998).

Punitive measures -- and/or the threat of same -- have also not served to induce large numbers of pregnant, addicted women into treatment (Turnbull, 1989). Many agencies and governments have devised these threats as a way to reduce prenatal substance abuse through the imposition of criminal penalties. However, evidence suggests that threats may have the reverse effect, discouraging pregnant women from seeking help for their addiction (Rasmussen, 2000; Stoli & Hill, 1996). Indeed, such measures may discourage pregnant substance abusers from seeking

any form of prenatal medical care at all (Resnik, Gardner, & Rogers, 1998).

The woman above, who lost her children to child protective services when she gave birth to them in the hospital as a clearly addicted person, must surely be aware of society's attitude toward her. More will be said about social stigma as it relates to treatment barriers in a moment. First, it is important to stress one last point. While the mothering role can definitely act as a barrier to treatment (whether the woman is pregnant or if she has already had a child), this does not mean that all women experience this barrier. Some women are child-free; some, who never wanted children, have borne them against their will; and some simply are ambivalent about the whole mothering role. Therefore, just as this very real barrier to women's seeking treatment for substance abuse issues needs to be dealt with in a constructive fashion -- one that meets with agreement from the mothers -- care must be taken that the response to this barrier does not turn into a barrier in and of itself.

Put simply, treatment providers cannot assume that all women have children or want to have children; therapy groups, self-help groups, or even individual therapy options must not be structured or run as if all women are mothers; and inpatient facilities that allow women to have their children with them while they are in treatment need to have at least some child-free spaces for women who (for a variety of reasons) might not wish to be around children.

### **6.3. Social Stigma, Negative Self-Perceptions, and Depression**

The great stigma attached to addictions in women leads many substance-abusing women to experience feelings of shame, embarrassment, depression, and guilt (Thom, 1986). Part of the reason for this was referred to above: society's different perceptions of male versus female substance abuse. According to Cohen (2000), society tolerates -- and even encourages -- males to drink, but frowns upon the same behavior in females, believing it to be "unfeminine." Several studies suggest that women with drug and alcohol problems perceive a greater stigma attached to substance use in women than men (Carter, 1997; Cohen, 2000; Copeland, 1997; Gomberg, 1988; Schober & Annis, 1996). From such stigma come feelings of guilt, shame, and embarrassment; from these feelings come poor self-concept, low self-esteem, and endeavors to hide the substance abuse from others to avoid further stigmatization. In fact, women have solitary drinking patterns to a far greater extent than men, who are more likely to drink in social settings such as bars (Annis, Graham, & Davis, 1987; Carter, 1997; Cohen 2000).

Findings in this study support these assertions, and suggest that women are well aware of the stigma attached to their addictions. This was evident in their responses to questions about the attitudes of their significant others to addicted women, which they overwhelmingly characterized as negative. Most of these women held deep feelings of shame, low self-worth, and embarrassment. Because of these feelings of

shame and low self-concept, women mistrust the social services system and other service providers (Echererry, 1997). The distrust may stem in part from the fact that these women frequently encounter the social service systems for numerous reasons. These feelings, combined with depression, often caused the women to be labeled as difficult, noncompliant and unresponsive to treatment, although the relationship between substance abuse and feelings of shame and low self-concept is not necessarily completely one-way. For example:

AFTC- I am currently on welfare and don't like how the people treat you when you go to them for something. Sometimes I would use before dealing with them. They look down on you as if you are a second-class citizen; it's just a job for them. She knew I was on drugs and needed an emergency voucher to feed my kids. They always think I am lying about something. This program has helped me with understanding who I am.

This woman's response indicates that her addiction served to intensify already-existing feelings of low self-esteem and shame. Her response suggests that she would use drugs to alleviate negative feelings of self-worth that come from the fact that the social services agency would look negatively on her. It appears that the social service provider not only

reinforced her growing drug addiction, but also served to reinforce the negative perception she has of herself.

The presence of a history of sexual (and other familial) abuse will be dealt with in greater detail in the next section. However, it is important to acknowledge that such histories generally bring about feelings of shame and guilt that, if not dealt with, can lead to extremely low self-esteem which, in turn, can affect the choice of significant others who both validate those feelings and perpetuate them. The woman's statement supports that cycle. She was placed in foster care and ran away to live on the streets (which, incidentally, is not a rare occurrence, and adds support to the fears women have of placing their children in foster care situations while they receive treatment for substance abuse). It was then that she began using drugs, and not long before she became a prostitute to get enough money for drugs. This began a cycle of ineffectual, abandoning boyfriends and drug dealing/prostitution -- woven through with continued substance abuse.

Again, as with the first woman in this section, it is difficult to tell which came first -- the low self-esteem or the substance abuse problem. However, once the addiction had been developed, it is clear with both women that each reinforces the other. Moreover, it is also clear that the absence of a supportive partner, who, at the very least, does not get in the way of treatment, is a hindrance to the obtaining of that treatment. The notion of a supportive partner suggests that the partner would encourage her by occasionally attending a group,

listening and talking to her about her issues and feelings, staying clean or trying to stay clean and attending a program themselves, helping her take care of her children, threatening to leave the relationship or to call child protective services if she does not attend the program, doing things with her to take her mind off drugs. Since love relationships are often one way, women obtain support, when those relationships are, unresponsive, that removes a primary avenue of support from the woman and, in addition, intensifies her feelings of low self-worth. More will be said later about sources of social support; but as one's sense of self-esteem cannot be entirely divorced from one's social relationships (especially for women), they bear discussion here.

Consider this statement from one of the nontreatment women:

NONTRT- I first got blasted when I was 13 years old. I remember sneaking my father's wine. I would hide and drink it. I got involved with my boyfriend while we were in high school. We would skip classes and go get high. We would return to class so high. My family members knew I had a problem with drugs when I refused to attend family activities with them. I thought about killing myself when I tried to cut my wrist. My boyfriend who I trusted became very violent and started abusing me. I couldn't trust anything he said. We broke up and I continued to use heavily. I tried about two treatment programs, I would go

to AA drunk, but I could never kick the habit. I have even tried counseling for my addiction. I became depressed when my boyfriend and I broke up. I have never been treated for depression. I have tried programs and I'm not really sure if a program can help me.

Although this woman does not say why she first took a drink at the age of 13, the fact that she "would hide and drink it" suggests early feelings of shame and embarrassment -- which, in turn, indicate early negative feelings of low self-worth and self-esteem. The fact that her family apparently did nothing to help her even when they "knew I had a problem with drugs when I refused to attend family activities with them" must only have served to intensify her feelings of low self-worth and depression (so much so that she attempted suicide). Even though she broke up with him, her abusive boyfriend helped reinforce a belief that she cannot trust anyone (which is a concomitant barrier to treatment, for trust is a necessary part of the process -- at least insofar as trusting one's caregivers, or at least the model of recovery one is following).

#### **6.4. Family Abuse and Victimization**

Abuse and victimization appear consistently in the literature on women's addiction. A history of victimization, in fact, is among the strongest predictors of substance abuse in women (Schober & Annis, 1996). Familial substance abuse, violence, and victimization are especially common in female

addicts (Chermack et al., 2000). It has been proposed that the experience of abuse can inhibit treatment seeking and recovery by contributing to depression, low self-esteem, and diminished expectations that one has the power to achieve a successful outcome (Cohen, 2000; Wilson & Anderson, 1997). In short, familial substance abuse, violence, and victimization are especially common in female addicts (who are, again, less likely in male-dominated treatment paradigms to receive the treatment they need to recover from such histories of familial violence and abuse).

Although the majority of the existing studies are quantitative in nature, findings in this study corroborate, from a qualitative perspective, many previous results. Not only were most of these women victimized either by family members or significant others, but they also experienced victimization at a very young age. The frequent result was low self-esteem and depression (illustrating, again, the entwined nature of these two categories). Consider this representative statement:

AFTC- My parents made sure I was taken care of. I can remember when my mother remarried after divorcing my father. I was around the age of 12. I was well developed at the time. I was very angry at my mother because of the divorce. I tried everything to break up my mother and stepfather. When I felt my mother not paying any attention to me, I starting running around with the wrong crowd,

skipped school and starting smoking, drinking and snorting cocaine. My mother tried to admit me in mental institutions. I had an uncle that I started becoming attached to. He was actually only a few years older than me. He introduced me to drugs. We became romantically involved although my mother was not aware. At the age of 14, my uncle was 21, we decided to move away. My mother was upset, but it appeared she was more preoccupied with her new husband more than me. After we moved to a new town, he controlled me. He abused me and told me to hustle for our next fix. He told me I would amount to nothing and wanted me to have anything to do with any other male. I was arrested many times for solicitation to support both our drug habits. When I was ordered into this program, this was the best thing for me. The program gave me an understanding of what I needed to do to get my life back in order. I face my problems through therapy. This program helps me get in touch with my feeling by helping me to understand who I am, and what I need to do to succeed in life.

In the case of this woman, her drug addiction stemmed directly from her experience of incest at the hands of her uncle. Interestingly, because she still calls what happened a "romantic involvement," one might wonder how far she has come in recovering from this abuse. In any case, she experienced sexual

abuse, but she also experienced emotional abuse and neglect from her mother and father. Her father seems to have disappeared from her life when he and her mother divorced, and her mother "was more preoccupied with her new husband...than me." Unfortunately, this is not an atypical occurrence; mothers all too often, for complicated reasons, side with the men in their lives over their daughters. This can have a devastating effect that compounds the experience of the sexual abuse.

Once she was "with" her uncle, the repeated experiences of prostitution and being arrested served to replicate the abuse. His emotional abuse of her (which has to be considered in a different light than the verbal abuse many women experience at the hands of their partners, both because of her age and also because of the incestuous nature of their "relationship") was yet another form of abuse with which she had to deal.

All told, she is quite lucky that she found a treatment program that would deal with all the aspects of her life -- not just the substance abuse. The preponderance of sexual abuse (as well as other forms of abuse) in the histories of substance-abusing women indicates, if not a causal relationship, strong correlations that indicate the abuse must be dealt with directly. She is also aware that she is fortunate, as she states that "(w)hen I was ordered into this program, this was the best thing for me."

This next woman contended with probable neglect at the hands of her mother as well as physical and sexual abuse at the hands of one of her cousin's older friends:

INPT- I was raised by my mother. I had four other brothers and sisters. We all have different fathers. I'm the oldest. I had to watch my brother and sisters when my mother would work or mostly go out. I started using weed when I found it in my mother's bedroom while cleaning. I had cousins that stayed in the apartment below us. I would hang out with them. Most of my cousins were boys. I would smoke and drink with them. I started dating one of my cousin's friends, he would sexually and physically abuse me and use me to get his drugs. I left home at age 16 and started living with him. I knew no one else would want me. He would bluff people and would not let me do anything on my own. I had two children by him and he would make sure I would not leave the house or have anything to do with anyone. He would beat me and when he broke my nose, I had to go to the hospital. I reported him to the police, and they let me see an abuse counselor. I was placed in a shelter with my children. They referred me to the program and I was able to get my life back in place. I had low-self esteem and did not know until I came to the program that I could help myself and my children. They also help me with parenting

classes and budgeting and I will be able to get my own place.

Although it is a classist mistake to assume that all women are neglecting their children when they leave them in the hands of their oldest sibling so they can go to work, this mother left her children in the hands of their oldest sister to "mostly go out." Furthermore, while again it is not entirely true that the existence of five children who all have the same mother and different fathers is an indication of anything dysfunctional on the part of the mother, it is certainly quite a warning flag. Therefore, this woman, as a child and young girl, most probably had very little mothering, probably bordering on neglect.

Further evidence of this exists that she found marijuana in her mother's bedroom while cleaning. Reportedly, this was her first experience using drugs. Yet again it is hard to make assumptions about this situation; for example, it is possible that her mother tried very hard to hide her drugs but simply did not do a good enough job. However, it is also quite likely that she made no effort whatsoever; perhaps not even considering what her children might do should they come upon them. Final evidence of neglect is that she left home at the age of 16 years, knowing "no one else would want me," to live with a friend of her older cousin who beat and raped her. Apparently, her mother did nothing to try to stop her.

She clearly had had sufficiently strong and numerous messages about her negative self-worth from her mother's neglect (as well as whatever else she dealt with that is not contained within this statement) that she felt, by the age of 16 years, that she could do no better than to be with a man who physically and sexually abused her. Somehow, however, she had retained enough sense of self-esteem that when she was referred to the Austin program, she followed up.

The next example is of a woman who, while she did not experience abuse during her childhood, was raped -- in part, due to her drug addiction. This experience with sexual victimization continues to affect her life, as does her addiction to crack cocaine.

NONTRT- I grew up in a house with ten brothers and sisters. I have never been in a treatment program and I hold a steady job. I know I have a problem with crack, but I have never been arrested. While using drugs, I was raped by a person that I thought I knew and had a child by him. I wanted nothing to do with him. My son was born and I continued to use drugs. Some of my brothers and sisters are alcoholics and drug users, but my father and mother never used drugs or alcohol. I remember my mother and father's fathers used alcohol. I cannot remember being sexually abused by anyone while growing up. The man I am now with

does not use, but drinks. I have two children by him and he knows I use; he does not like it but tolerates my using. I do have problems communicating with my children, and my son also uses. He has bought for me on the streets several times. I cannot seem to kick the habit, but I cannot control my habit. I don't feel I can afford to go to a treatment program. I know I need to, but I need the income to support my kids. My ole man has a job, but I'm not ready yet.

It is not a big stretch to surmise that part of her problem communicating with her son concerns the fact that he was conceived through rape. "I do have problems communicating with my children, and my son also uses." It seems that these "children" to whom she refers are those who were conceived with the man she is currently with, and it is quite telling that she separates the son she bore before from the classification of "her children."

There were numerous other examples of women in this study who experienced some form of familial abuse. It is very interesting to note that most of the abuse was sexual in nature. Consider these words:

INPT- I have never been able to trust anyone. I was abused by my stepfather at age six and could not trust my mother. When I told my mother, she said I was not telling the

truth. I also became a very angry girl and wouldn't let anyone close to me. I felt that people wanted to use. I felt I could not trust anyone at all.

AFTC- I had cousins and uncles that were my age that would abuse me when I was 5 years old. I thought they were showing me love. When I started high school, I was told by a friend that this was not a good thing. I was sexually active with boys in high school and thought that showing them love meant having sex with them. I starting using drugs and sold my body for drugs.

NONTRT- I am a product of divorced parents. I was abused by my stepfather. He refused to allow me to have a relationship with my mother. He always tried to keep us apart. My mother seemed not to realize what was happening. It seemed that she loved this man more than me. I left home after graduating and became involved in a lesbian affair. My partner was an alcoholic and was physically abusive. I stayed in the relationship for years thinking she would change. I also started using while in the relationship.

INPT- My father was an alcoholic and would have sex with me and my sisters when we were small. He would come in our

room and rub us between our legs. My mother was also abused by my father. She felt she could not do nothing for us.

When I graduated from high school I said I would not have anything to do with my father and surely would not date any one like him. I met a guy who was abusive and a drug user.

When I saw he was trying to abuse my kids, I ran to a shelter and left him. I stayed in this relationship too long.

Other women in the study experienced victimization at the hands of partners whom they chose in part because their home lives growing up offered no positive role models for healthy love relationships.

INPT- I grew up in a family where my father and mother used drugs. They would beat and whip me. I also had sisters that they would beat too. I ran away from home when I was 13 years old. They never came to find me. One day I ended up in a shelter and started going with a man that was way older than me. He told me he would take care of me and we lived together. He would beat me and made me go out on the streets to get money for him. That's how we'd pay the bills. He would not let me come home until I would make a certain amount of money.

AFTC- I was in foster care all of my life. I didn't know my mother or father. I was once told my mother died of a drug overdose. After graduating from high school, I began staying with a man that also used drugs. He would beat me and want me to have sex with him after he beat me. I had kids by him and had nowhere to go. One day he left us for another woman. I got on welfare and tried to get my life back together. I was a heavy drinker and tried to keep my kids together. After coming into the program I think I will be able to keep my kids together.

Finally, as noted in the literature review, while a family history of alcoholism and violence is linked with current alcoholism for both men and women, the association has been found to be much stronger for women (Chermack et al., 2000). "Some of my brothers and sisters are alcoholics and drug users, but my father and mother never used drugs or alcohol. I remember my mother and father's fathers used alcohol. I cannot remember being sexually abused by anyone while growing up." If she alone out of her ten siblings -- some of whom are also female -- was addicted to drugs, this family connection might appear tenuous. As this is not the case, however, we may view this woman as an example that helps confirm earlier research in this area.

### **6.5. Lack of Social Support**

Studies have proposed that a lack of social support presents a major obstacle to women in seeking treatment for

addiction. Addicted women are often involved in a relationship with a partner who shares their addiction, which may be a central barrier to women's seeking treatment (Zelvin, 1999), because these co-addicts typically encourage their female partners to continue their drug or alcohol use (Cohen, 2000; Leonard & Das Eiden, 1999). This type of social network offers female substance abusers minimal support for recovery (Beckman & Amaro, 1986; Miller, 1998; Wilsnack & Wilsnack, 1991). In contrast, a substance-abusing woman who has social supports that encourage treatment seeking is more likely to do so.

Qualitative findings in this are consistent with much of the quantitative research on the importance of social supports in seeking treatment and recovery. Most of the women in this study were influenced by boyfriends, partners, or significant others to engage in substance use and actively discouraged from seeking treatment. Friends because of their substance use abandoned others. In short, many women felt that social support from their families and friends was necessary to enter treatment, but the kind of support they needed to overcome their addictions often was missing.

The women whose interviews were presented below express variations on the lack of social support. The first understands that she "burnt her bridges" with her family and friends but somehow overcame that obstacle on her own. The second had some help overcoming this obstacle from the courts, but still understands the work she needs to do to mend the relationships

in her life. The third woman does not have any support and has not found a way to surmount that barrier; instead, she avoids her family and friends and continues to use.

INPT- I burnt my bridges with family members and friends, so I never expected them to help me with anything. There has been many times that they would loan me money or keep my kids, but I would not pay them back or would leave my kids with them for days. So when I started treatment, my family and friends did not believe I was going into treatment so they would not help me.

INPT- My partner was at first very helpful with my kids. I could talk to him and he would feel sorry for me. He stopped using drugs and wanted me to stop. It was hard for me to stop. He did not want to keep my kids because that meant I would keep coming around him. He tried to contact my family, but they would not help as well. They wanted nothin' to do with me. I got so strung out on drugs until I had no one to turn to. The courts mandated that I go to treatment, I got my kids back, but my family still does not trust me.

NONTRT- My family and friends were very upset at me because I would tell them many times I would get help for my drug

use and would never do so. They would not give me any more money so I would steal from them. I would steal any kind of household goods and pond it for my drug use. My family would shun me and would not speak to me in public. They would keep their distance in hopes that I would not ask them for anything. I never go around them because they won't accept me.

On the other hand, those women who do have support often cite that support as the reason they seek treatment. Consider this response:

AFTC- I am closest to my father. My father stuck with me throughout my program. I am currently divorcing my husband. Being close to another person means someone you can depend on and you can trust. I can trust my father but not my ex. My friends lost trust in me when I started using. I could not keep friends. I betrayed them. I can turn to my father for help. My mother and I do not have a close relationship. My ex also used. He was the one that introduced me to the drug. I entered into treatment when I knew my father was tired of my behavior towards him and other people. He was embarrassed with me. Since I have had treatment, I don't go around my old friends that use. The friends who did not use, have accepted me, but they are cautious when I come

around. I do have one child, and when I was pregnant, the hospital found drugs in my child and threatened to take the child. My father suggested treatment and he paid for it. Aftercare treatment has also helped me with budgeting, housing, and being able to find a job. The program encourage you to get into a twelve-step program after in-treatment. I religiously attends my meeting, sometime three time a week. Since I have left the program, I do not spend time with other people that use. Some of my old friends that I used to use with give me grief about using. I ignore them and refuse to return to my old habits. I have learned to cope in the community. I have learned to be strong since I have been back in the community. I have not slipped, but I do have cravings for the drugs, but I try to return to my notes that I received while in treatment. The aftercare program also is very helpful with retraining me. It helps a lot.

Perhaps the most telling statements in this passage are: "I entered into treatment when I knew my father was tired of my behavior towards him and other people," and "My father stuck with me throughout my program." This woman was introduced to drugs through an ex-partner, and in fact continued to use through her pregnancy. When the hospital found drugs in her system while she was pregnant, they threatened to take her

child. Whereas some of the other women felt immediate fear and shame without the support that would get them more easily through the situation, this woman had her father by her side. Instead of abandoning her because of her substance abuse problem, not only did he suggest treatment, but he offered to pay for it.

This is shown in another woman's words as well. This woman had more than one source of support: she had her husband and her family. And even though she expresses upset that "it is hard for anyone to believe you about anything," in a way she also understands that this is one way support is offered.

AFTC- My husband has supported me with the kids. I started treatment and stayed for 90 days. When I got out of treatment. My husband would watch me like a hawk. I could not go anywhere unless he knew where I was going. I could not spend money without him knowing what I was spending it on. I could not ask my mother because they would all call each other to make sure I was not using them. It is hard for anyone to believe you about anything.

While of course not all people in one's support system could afford such a financial investment, it is the emotional support that is the most important. Had he not been able to afford a treatment program, being a supportive parent, he could have offered to care for her child while she attended a

treatment program. With the fear for her child's safety gone from her consideration, she would have felt more able to engage in a recovery program with her full attention. Keeping this in mind, consider this next response from another woman who is not fortunate enough to have even one person in her social support system:

INPT- Being close to another person means they got your back. They will do anything for you that they can. Everybody in my family wants nothing to do with me. I have no friends or family members that I can trust and depend on. Everyone in my family know about my problems with crack and they want nothing to do with me. I had many boyfriends that used drugs, I can't depend on them. I could never keep friends. I had a baby, and I really don't know who the father is. I have no family that will keep my child if I needed them. People that I know don't believe I will change, I have been in and out of programs before and ended up back in programs. People make me feel that I can't make it in life, maybe that's why I don't make it. I been in the program for about six weeks and I listen to what my counselor and other people in the program has to say, so we will see at the end what will happen. I can only say I will try.

This is a person who is fighting, against the odds, to make the rehabilitation program work despite so many in the past that have not been successful for her. She is very aware of the handicap that exists in her lack of a support system. It is very telling that her first two sentences describe what being close to another person is all about, and almost the full text of the rest of the statement explains why she does not have such a close relationship in her life. She states: "People make me feel that I can't make it in life, maybe that's why I don't make it."

While on the one hand, people cannot entirely blame their substance abuse problems on others, it is true, on the other hand, that support is critical in the effort to recover from an addiction. Again, while it is not always discussed overtly, men frequently have this support, from partners and other people in their lives (Bischoff,etal, 2000). Furthermore, while support networks (McMahon, 1998) are important for all humans (being that we are, after all, social animals), they tend to be especially so for women; whether due to socialization or genetics, it tends to be true. So, the woman above has not only had trouble sticking with a treatment program due to the barrier of a lack of social supports, but it is sadly all too possible that she will have trouble when she leaves this program -- with its built-in support network of fellow clients, therapists, and other staff members -- and tries to maintain her sobriety on her own.

Some women have a "mixed bag" of support. Consider the words of this woman:

AFTC- I have been in one other treatment center. My parents kept my kids and this time was very unsure if they wanted to do it again. They asked that I not call or write the kids and prove to them that I would make it this time. I wanted my kids to stay with family members so I agreed to do so. I also agreed that I would not come around the kids until I prove to them after the program that I am drug free. My family knows when I am using by the way I act. I have been drug free for three months but my family still feel that I need more time away from the kid.

Finally, consider this statement from a woman who used to have a central support system in the form of her mother, but tragically lost it:

NONTRT- I used to be close to my mother before she passed away. I could depend on my mother for everything. I started using drugs after my mother passed away. I became depressed and felt that my world had crumbled on me. I began closing myself away from people and I have no friends. I'm not involved in a relationship with anyone at the time. I recently quit my job and am now homeless. I have one grown child. My child knows I have a problem, but does not want or maybe she's afraid to have anything to do with me. My friends know I have a problem, but feels that I have mental

problems, not a drug problem. My son and friends keep asking me to get help, but I don't know where to start. I do have people on the streets that uses with me, but I don't really call them my friends. I may see them every once in a while in food banks and in shelters. I have been in and out of jail for possession of drugs and soliciting for my drug habit.

Not only did this woman lose her main source of social support, but also this was her stated reason for starting to use drugs in the first place. "I started using drugs after my mother passed away. I became depressed and felt that my world had crumbled on me." It is interesting that she mentions friends as well as a grown child, and still feels as though she has no social supports. Perhaps this is because, although they supposedly represent her support system, they have not offered her housing and, as a result, she is homeless.

Miller(1993)recognized that a person's sense of self-worth and self esteem can be affected by association with a person who has a lack of self-worth. It is a matter of being discredited because a member of the family has characteristics that are perceived negatively. With this in mind, women who are associated with partners who are willing to engage in the process of her treatment can assist the woman in overcoming obstacles and enhance the likelihood of a positive outcome for the woman.

Many of these women, although oblivious to the importance of having a social network to rely on, have a tendency to "burn their bridges," making any means of support difficult for them. The women come to understand how making amends with family members and others can be essential to their recover.

## 7. CHAPTER VII

### 7.1. BARRIERS TO TREATMENT ON THE BASIS OF RACE/ETHNICITY AND CLASS

This chapter will look at the differences in experiences and perceptions of and overcoming barriers to treatment and recovery among substance-dependent women based on race, ethnicity, and class. It has been suggested, that these factors intersect, impacting treatment seeking by diminishing access to appropriate treatment for women of color and working-class women. Because these women are less likely than middle class white women to have health insurance or be able to afford child care so that they can enter treatment.

Ample research has been done about the connections between race/ethnicity and class and substance abuse and the interaction of these with gender. This is especially true regarding class. Several studies have demonstrated a strong association between substance abuse in women and low socioeconomic status (e.g., Herd & Grube, 1993; Parker & Harford, 1992); and women in treatment for alcohol abuse are more likely to be unemployed, or earn low incomes, and have few economic resources, as compared with their male counterparts (Beckman & Amaro, 1986; Carter, 1997; Weisner & Schmidt, 1992).

However, little research has been done to specifically investigate how race/ethnicity and class act (or not) as

barriers to treatment. Those studies that have been done have suggested specific ways in which having a low income can have an inhibitory effect on the entrance of substance-abusing women into treatment. Treatment not only costs money in direct payments, but there are indirect costs such as transportation costs, as well as foregone income (Copeland, 1997; Beckman and Amaro, 1986). Low income women are also far more likely than middle class women to have to rely upon Medicaid as their source of health insurance (Carter, 1997; Young, 1996), which many treatment providers are reluctant or unwilling to accept (National Center on Addiction and Substance Abuse, 1998).

As mentioned in chapter four, in the aftercare group 50 per cent of the women had a high school education or less. Eighty percent of the same women reported \$20,000 or less in annual income. And sixty percent of the women self-reported as Hispanic. Women in treatment for alcohol abuse are more likely to be unemployed, or earn low incomes and have few economic resources as compared with their male counterparts (Beckman & Amaro, 1986; Carter, 1997; Weisner & Schmidt, 1992). For example, a 32 year old Hispanic, who has a 6<sup>th</sup> grade education and made less than \$8000 a year states:

I had been drinking most of my life. I knew I needed to clean up my life but did not have money to enter a drug treatment program. I did not make much money and my jobs had no insurance. It was hard for me to let go of the

drug. I got into some trouble and ended in this program.

In the inpatient group seventy percent of the women had nine years of formal education or fewer, and none of the women had an annual income exceeding \$15,000. This group was fifty percent Hispanic as are the aftercare group. Consider the woman who is a 24-year-old white female, who possesses her bachelor's degree. The opportunity of obtaining the resources and support from her employer based upon her race\ethnicity and class, are excellent. She reports:

I started drinking while I was in college. I had a good job doing clerical work. I began missing time on my job and would not go to work at times. My supervisor knew I had a problem. She told me about a program that would allow me to seek treatment and keep my job. My insurance is paying for my treatment.

In the nontreatment group all women reported incomes of \$5,000 or less, and all had 12 years or less of formal education. 40% were Hispanic, 30% white and 30% black.

Women of color also have to deal with the failure of treatment programs to acknowledge and appreciate their values, beliefs, and practices, which might lead them to drop out of treatment altogether (Castro et al., 1999; Echeverry, 1997). Because many black women or other women of color with a history

of treatment for substance abuse have had negative experiences with treatment providers, they may only seek treatment when faced with a crisis. They may avoid treatment because of previous experiences with providers who are insensitive to their needs.

Consider the testimony of two black women who explained their barriers to treatment.

AFTC - This program is my third program and I have been please with this one. The first two programs I was in did not understand where I was coming from. I was not able to understand if the counselors knew what I was going through at the time. The criminal justice system did not give me a chance to prove myself with getting a job and going back to work. They just thought since I was black, I needed to be in jail. I was upset with the system, so I just started using again and got back in jail.

NONTRT - I tried the program stuff and found I had nothing in common with the other people. They did not understand that I needed to talk to someone of my own kind. I did not feel that I could trust people to talk with them. This counselor who was white told me that she knew what I was going through and that was a turn-off for me then. She did not know what I was going through.

These two women express their need to identify with someone of their own kind. They felt that they could not trust the counselors and needed someone of their own race and background to identify.

Findings in this study also suggest that social class position impacts treatment seeking. This was evidence in three dimensions of SES - income, occupation and education. For example, consider this response from a 55-year-old white nurse with an income that(at one point) exceeded \$50,000.

AFTC- I have been an alcoholic and abusing other drugs for years and due to the stress of my job working both day and night shifts, I drank alcohol on a daily basis to calm my nerves. This is my second treatment program and I have been having been having problems staying sober. I got my second driving while intoxicated charge and decided to get into treatment.

This woman reported that her major barrier in initially entering treatment was her embarrassment at having to inform her employer of her addiction to prescription drugs, which she often stole from the hospital in which she worked. She was terminated for this and subsequently became addicted to cocaine. She realized her problem when she became depressed and depended on the drug to get her through the day. Since her health insurance was still in effect, she was able to enter treatment.

A twenty-one year old white female who worked as a sales representative for a small pharmaceutical company making \$15,000 a year reported that she started using while she was in college. However, because she had the support of her family, she was still able to obtain treatment for her addiction, despite her low income.

INPT- I started using stimulants to help me study for my exam and then began using cocaine. I started working for this company and could not get to work on time. I also had a kid while I was in college and my parents helped me with her. I got involved with a social group at work and started using heavily. My family saw that I was out of control and my parents offered to pay to place me in a treatment program that would allow me to keep my child.

Compare her statement with this one from a 42-year-old female who worked as a part-time clerk making \$9,000 a year. The difference in income does not seem all that substantial until it is understood that she has four children. She had been getting child support from three of the fathers of her children, but support from a broad-based extended family was non-existent. This woman is also African-American, which might have made a difference in the decisions concerning the placement of her children as well as her initial sentencing.

INPT- I started using drugs from one of my baby's daddies.

He was a dealer and I would also sell drugs for him in my complex. He would abuse me and I felt that I had to sell the drugs to get along with him. One day a cop bought for me and I got jail time for three years. Child Protective Services took my children and I had to show them I wanted to straighten up to get my kids back. There was no way I could afford to get into treatment without the courts making me come to treatment.

Class also intersects with race. Many minority women, despite higher rates of labor force participation, are disproportionately poor and working class, have suffered from higher unemployment rates, greater difficulty finding full-time, high wage jobs and are much more likely to be single parents (Amott and Mathaei, 1996). Although work has appeared to be more plentiful for minority women, many tend to be employed in lower paying jobs compared to the high paying though less secure jobs of their male counterparts (King, 1993).

Consider this next statement of a twenty-five year old Latina woman who had been earning \$25,000 a year as a computer technician and now finds herself between jobs. She tells her story here.

AFTC- I would show up on my jobs and could not perform the work. My boss would ask me what was wrong. He fired me for not being able to perform. My job did not have benefits for

me to go to a program. I could not afford treatment on my salary and take care of kids too. After months trying to seek other jobs, I used heavily selling my body to support my habit. Many times I would dodge authorities not to return to jail.

Eventually, a court mandate accomplished her goal of seeking treatment. More than half of the other women in this study, in fact, were in the Austin Recovery program by court mandate. Without such court mandates, many women who desired treatment would not have received the help they needed. For example, a 26-year-old African American who also realized she had a problem but whose income was less than \$7,000, knew she could only enter the program due to a court mandate. She had never considered entering a drug treatment prior to the court order, because she could not afford it.

At times a court mandate does not come soon enough to avoid serious consequences. Consider the forty-five year old African-American woman who worked as a factory worker making \$19,000 a year.

AFTC- I functioned on the job for 15 years until my health began to fail. I was a functional user and used on weekend and sometimes after work. I started out using weed and then I needed something stronger. I used crack cocaine for several years until I began to have heart problems and had a mini stroke. I was fired from my job and could not afford

to go to a program. My drug habit put me in violent situations with my boyfriend and I stabbed him. I went to jail for 24 months and they offered to get me in a treatment program. I'm glad I did.

It is tragic that this woman had to experience such a precipitous decline in her life -- from long-term job to unemployment to a crack habit to serious health problems to, finally, prison -- before she was able to obtain the help she needed. This is an example of how society fails certain groups of people. It is especially lamentable that she is happy to have received help. It is very possible that had someone intervened sooner, the several years she spent in decline might have been avoided.

This next woman also experienced quite a few dangerous and difficult life situations until she got the help she needed. She was a member of a Latina gang from the time she was fourteen years old, and got involved with drugs as well as perpetrating violence while she was still involved with them. Although she is not out of the woods yet, it is heartening that she is still quite young (only twenty years of age).

INPT- I had a very bad attitude and got involved with a bad group. My baby's father was also in the gang. We both became involved in drugs and started gang-banging real bad. I got in trouble with the cops when my gang put another girl in the hospital. My mother kept my kids while I spent

some time in the slammer. I didn't hear anything from my baby's daddy while I was in jail. The courts ordered that I go to treatment and threatened to take my kids if I did not do what the courts said. I am on probation for another year and I got to keep my nose clean.

Before considering those who are not in treatment (and whose choice in the matter is at least in part related to race and class), it is instructive to examine some of the basic trends so far in the women's responses to see what conclusions may be made. First, it is clear, as stated above, that low socioeconomic class does indeed act as a barrier to treatment. Even though some do receive treatment, there is a high waiting list for court mandates. Either women assume they cannot afford it and so do not even bother to investigate their possibilities, or else they know that they cannot afford it. At times, class status does not act as a barrier to treatment; but that is when the women have an existing social support network which is willing to purchase treatment and able to do so.

Class is not only a barrier in terms of actually being able to afford the treatment itself; it is also, as suggested in other studies, a barrier when the women consider the costs involved in caring for their children. It is ironic that the only way some of these women were able to enter treatment while ensuring the well-being of their children was to go through the court system. In a society that has an over-burdened justice system, it seems to make no sense that so many women are forced

to further tax the system when, in actuality, it only acts as a middle-person to the real goal: treatment for addiction. In other words, if treatment was available to all who needed it, imagine how many fewer people would be facing charges for crimes ranging from stealing to physical assault -- and imagine how much money would be saved.

Second, this study did not directly indicate that race or ethnicity act as barriers to treatment. However, because there is not a direct link (i.e. no one said that because of her race she was unable to obtain treatment, or was unable to obtain treatment that was not biased against her because of her race) does not indicate that race/ethnicity do not act as secondary barriers. For example, the 55-year old white nurse was charged with driving while intoxicated for the second time and decided on her own to get treatment, while the 42-year-old African-American part-time clerk was arrested for buying drugs from an undercover police officer and received three years in prison. Clearly, this represents a disparity that has at least something to do with race.

Finally, consider two statements from women who are not in treatment. The first is a thirty-six year old white woman who works as a secretary making \$30,000 a year. She considers herself to be a functional alcoholic. The second is a thirty-three year old Latina who works as a waitress and earns \$12,000 a year. She realizes she is addicted to drugs, and has tried twice to get clean.

NONTRT- I was once arrested for driving while intoxicated and paid the fine. I really don't consider myself as an addict because I can hold my own. I am able to work even while drinking on the job. I once attended an outpatient treatment program and I was still able to function at work. My job has benefits for a thirty-day program and I was able to complete it. My family and friends tell me that I can change when I drink heavily. I was arrested once for driving while intoxicated, but I allow someone else to drive.

NONTRT- I have been in two treatment programs and tried to stay clean for years. I was given another chance at life. The last program I was in I decided I would straighten up my life because I lost my kids. The courts ordered me to go to treatment because I could not have afforded it.

These two women are different in race as well as class. The first woman is white and middle-class; the second is Latina and working-class. The first has health insurance that allowed her to obtain treatment at a time of her own choosing, while the second would have been unable to obtain treatment had it not been for the courts ordering her to do so. The first woman has no real reason to work on her addiction: her family and friends have not abandoned her, she still has a job, and she still has a car. The second woman has lost her children.

It is, of course, impossible to generalize from these two women to make statements about how race and class intersect with substance abuse issues and, in particular, act as barriers to treatment. However, there is enough anecdotal evidence -- in these two statements as well as numerous other relevant places -  
- to warrant significant further research.

## 8. CHAPTER VIII

### 8.1. POSSIBLE BARRIER-FREE TREATMENT MODELS

The main reason to conduct research of this kind -- the only reason to seek information about what problems exist in a particular situation -- is to alleviate those problems. If no solutions are forthcoming, the information becomes lifeless. There are two ways to bring information to life in an effort to solve problems. The first is for the researchers and others to analyze the data and draw their own conclusions. The second -- and the one I see is superior -- is to pay attention to the perspectives of the participants themselves in developing statements.

This chapter will examine what the perceptions of substance-dependent women can tell us about a possible treatment model that is accessible and effective. How important is gender sensitivity in treatment programs, as evaluated by women who have sought treatment and those deterred from doing so, in helping to overcome barriers to and remain in treatment?

The findings here suggest that male-centered treatment programs inadequately address the treatment needs of women substance abusers. The perceptions of the women in this study point to two primary concerns: childcare and having their children with them and family support services. As previously

mentioned, many of the women had no child care resources or feared losing their children if they entered treatment; these negatively impacted their treatment seeking. These concerns were not applicable only to young children. The women also wanted their teenaged children with them. Their perceptions of a better-designed program included less restricted communication and more visits with family members and children and meetings that would bring their families to the program.

Their perceptions also indicated the need for more counseling sessions, particularly with regard to such topics as coping skills, building self-esteem, in-depth family and parenting education, and relapse prevention. Programs also should be more sensitive to women's medical needs and encourage women-only self-help groups. Moreover, program counselors and clinical staff who treat substance-abusing women should have advanced training in the full range of issues that lead women to addiction and in helping women to recognize, understand, and cope with depression and negative life events. The findings also indicate the possible need to restructure financial access to treatment programs for substance-abusing women.

1. Childcare: What would a relatively easily-implementable, easily-accessed, effective model that sidesteps the traditional problems of male-centered approaches and is designed to meet the stated needs of women look like?

First, it would include care coordination among developmental evaluation services and children's treatment

providers or support services, such as counseling and tutoring, for school-age children in the evenings.

One way is to allow women to have their children with them as they work toward recovery. This is the most obvious and the most easily-accessible (and cost-efficient) solution to the problem in comparison to other services, such as, prisons, children services, etc. All it entails is more room in the treatment facility (so that women can have larger rooms that will accommodate their children) and one or two more staff members who can watch the children while the women are doing their therapy and other group/individual work.

Some women might be distracted by the presence of their children, and some child-free women in the program would be distracted by the presence of children. Therefore, it makes sense to have other options.

One possibility would be to have women who had already completed the program and been clean for a given length of time be identified as foster mothers for the children of women in the program. They could be compensated at least in part for their work, and would have access to staff supervision. This arrangement could also work to the benefit of the foster mothers in the sense that they would feel this was something they could give to other women in recovery (holding in spirit to the philosophy of sponsorship in Alcoholics Anonymous, that by helping others work toward sobriety, one helps oneself as well).

Visits would be arranged -- not only between the mothers and their children, but also between the mothers and the foster

mothers, so that the women still working toward recovery could see what parenting was like on the other side of addiction.

This arrangement could be accomplished with relatively little financial expense.

Another option for overcoming barriers for women with children would involve considerably more time and effort, but it would be worthwhile in the long run. Put simply, it would involve working with current foster-care agencies (as well as law-enforcement and the judicial system) to ensure that the care provided by the foster parents is nurturing, loving, and trustworthy.

2. Abuse: The second-most commonly cited barrier to treatment was histories of sexual and/or other forms of violent familial abuse. Treatment programs that ignore this history are in many cases doomed to failure. If, in fact, the history of child abuse is a causal factor in the substance abuse, then how can the substance abuse be treated effectively without paying attention to it?

An ideal treatment model -- should incorporate a component that addressed issues of child abuse. This includes specially-trained therapists and the incorporation of therapeutic interventions into the overall treatment schedule. More than this, though, such a program would need to approach the entire area of substance abuse treatment from a different paradigm or less traditional treatment model than do most substance abuse treatment models (such as Rational Recovery or AA/NA).

Many treatment models focus solely on addiction as the primary problem, and for many women this is simply not the case. Moreover, groups like Alcoholics Anonymous have participants acknowledge that they have no choice, no will, and must surrender entirely to their higher power because on their own they are not able to oppose their addiction. The problem is that women who have been victimized have ongoing issues precisely because their choices were taken from them and they still feel like helpless, scared children. By reinforcing that vulnerability, AA and NA-style programs reinforce the experiences that, in part, led to the addiction in the first place.

3. Depression: This leads to a third (although strongly related) barrier to treatment indicated by the women in this study. That is the presence of depression, low self-esteem, and other psychological issues that treatment models ignore at the risk of allowing women to only address part of their overall mental and physical health problems. The research shows -- and the statements of these women corroborate -- that treatment models for women need to have a more holistic approach to health than traditional male-designed models.

One solution to this problem is already in place. Austin Recovery offers a variety of programs under its umbrella that appeal to women in a variety of situations and with a variety of needs such as the aftercare women's program. The aftercare group consisted of weekly meetings to address a wide variety of topics, from sexuality to self-esteem, that the women needed to

address in order to continue their recovery in a holistic manner.

Every week, the aftercare group began with the facilitator playing a relaxing musical tape for deep breathing. The women then introduced themselves by their first name only and as addicts or alcoholics. This is reminiscent of the typical AA or NA meeting. However, from here the group diverged. The group facilitator would lecture on different topics for the week; then there would be a break; and then the facilitator would request if any one had anything to process for the week. The discussions that ensued ranged widely, but most of them had little to do -- explicitly -- with addiction. In other words, the women were concentrating on bolstering the parts of their lives that had been damaged by their substance abuse issues as well as (possibly) contributed to them.

Another option that would help women overcome this barrier to treatment (and which would, incidentally, help with the previous barrier as well) would be to attach an educational program to existing models. Through a series of in-service workshops and seminars for addiction counselors, they being knowledgeable about the interplay of issues present in substance-abusing women could help raise the awareness (and the skill levels) of therapists and counselors working in more traditional models. If these practitioners could understand that for effective treatment, many (if not most) women need to have attention paid to more aspects of their lives than simply the substance abuse issue itself, that would, over time, help to

transform the traditional, existing models and, also in time, perhaps work to lower the barriers that exist as a result. There is no reason to throw everything away; it is often much easier to reform something that is already in place than to recreate anew. This approach would work from that perspective to eliminate barriers to treatment.

4. Social Support: A fourth barrier mentioned by the women in this study is a lack of social support. Unfortunately, there is only so much a treatment program can do to provide friendship to its participants. However, this does not imply that nothing can be done. One approach would be to engage "graduates" of the program in a growing web of support that would be accessible to incoming women. As with the childcare issue mentioned above, this would serve to help not only the women coming in, but also the women who had graduated.

With relative ease (and the work of perhaps one-quarter of a staff person), a list of names and numbers could be kept and given to women as they enter the program so they could at the very least know that if they ever wanted someone to talk to, they would have a number to call. Social events could be planned, perhaps once a week, in which women from the "outside," so to speak, would come and mingle with women in the intensive parts of their treatment. Among these choices, the women would stand a good chance of meeting at least one person with whom they connected -- either as a friend, or, at the "worst," an acquaintance who was supportive of their efforts to work toward recovery.

Thus, women would be able to find not only some new friends, but also friends who were not using and who, in fact, had a commitment to helping them stay clean as well. Furthermore, this approach could be implemented easily in almost any existing program, whether traditional or cutting-edge.

5. Financial: A fifth barrier as noted by these women is a lack of financial resources. It is this last barrier that the researcher finds the most difficult relative to creating solutions. Short of an overhaul in our medical or social welfare system, it is hard to imagine how to better deal with this problem -- at least for those women who need intensive inpatient treatment and/or ongoing work with trained counselors.

However, one option, for those women who have "graduated" from programs, would be to empower and assist them to set up, once they have some recovery time under their belts, weekly self-help support groups that would look something like the Austin Recovery aftercare groups. These would not necessarily serve the purpose of focused addictions support (as, for example, AA and NA meetings can provide), but they would serve the purpose of providing support for the other aspects of ongoing recovery that are so critical to women. Furthermore, they would be free of charge.

Another, more long-term, solution would involve professionals from alternative models coming together to lobby for changes made in the social services system that might help women get access to treatment long before the judicial system was involved -- but that would take advantage of the judicial

system nevertheless. The only drawback to this solution would be that it would appeal only to women who were already in the social service system. However, this is not a negligible population.

Put more simply, this solution would entail the training of social service providers to more accurately and more quickly assess their female clients for substance abuse issues. From there, contact might be made with one or two judges who would mandate treatment for the women so that they could receive it free of charge but without having to serve time or have anything on their records. This sounds a bit like getting around the system, and indeed it is. However, until free and effective treatment is a viable option for all women -- and all people, for that matter -- creative ways around the barrier of socioeconomic status are necessary.

At this point, responses of the women in the study will be examined to discern what solutions they envision to resolve the barriers to treatment encountered in traditional substance abuse treatment models. Among other things, one woman makes it very clear that the attitude of the counselors is a critical element of treatment:

AFTC- If I were to design a program, I think that the counselors could be more nicer. I think they see you as a criminal and talk down to you. I also think that they could have family come and visit more during the weekend. I had a

medical problem that I thought they could have seen to it that it was treated earlier. I think the program drilled things in me for my drug habit that I knew I probably couldn't get it anywhere else. I also felt that the food could have been a little better.

This woman suggests that, she is being viewed as a criminal. It would be hard to imagine a less-conducive environment in which recovery from substance abuse issues could commence -- especially given the fact that so many of these women have serious issues with low self-esteem. Beyond the mental health aspect, if counselors take the approach of "talking down" to their clients, then very real physical health issues are ignored, as the woman's statement above points out. This is an unfortunate situation, not only for the client, but also for the program itself, should something truly life-threatening go untreated.

Finally, although it might seem like a small thing, good food is indeed important. Women who are undergoing the removal of the very thing that has given them comfort for so long (albeit in a highly destructive form) need replacements. Food -- especially for women -- is a classic form of comfort that is easy to provide. In fact, this brings up the fact that the provision of comfort in general is a good idea for women (and men, for that matter) in treatment programs. Art on the walls, comfortable places to sit, a pleasing, soothing color palette -- all these things are easy to provide, no more expensive than

making a facility uncomfortable, and they help ease the transition from using substances as comfort items to finding more healthy alternatives.

Consider next the words of the two women below who, among other things, speak to a barrier not hitherto stated: the absence of enough female counselors:

AFTC- I see the important needs for women in a treatment program to look inside of them and know what they really need as a woman. I had a male as a counselor and felt that he really couldn't identify with me. I felt that I could still get something over on him. But then when I talked about issues concerning my kids he would know exactly what I was talking about giving me examples of how kids treat their mother differently from their father. I think that weekly counseling sessions would be more longer than an hour and more times a week. I had a 90 day treatment program, I feel it should be longer.

NONTRT- I had a 30-day treatment stay with a program and felt that it was not enough time. I also had classes with men and with men counselors. I felt the counselors did not know what to say to me or give me a straight answer when I talked about issues like my being abused by my father or my partners. I also had kids and after treatment I could not

find anyone to provide childcare so I could not go to my scheduled meetings. The program also placed a strain on my finances. I was not able to work and lost wages. I wish they had a number to call if I relapsed.

Both women point to a very salient issue: the real or perceived inability for male counselors to understand or empathize with their issues. The first did say that when speaking about certain things like issues regarding children, her counselor was actually able to offer her some helpful feedback. However, she also pointed out that when it came to looking inside and knowing "what they really need as a woman," he was (understandably) unable to be helpful.

The second woman brings up an even more critical matter. Most of these women who have histories of childhood abuse (or experiences of adult victimization) had men as their perpetrators. While in theory they should be able to separate the male counselors, who are there to help, from the males who abused them, the reality is that this is a skill that takes a very long time and much effort to cultivate. Furthermore, when one is dealing with issues of substance abuse, trust is a very important factor. Without the ability to trust one's own counselors, how can these women progress? The absence of at least the bare minimum level of trust undermines whatever gains they could otherwise be making. This refers back to the point

about treatment programs being sensitive to the overall needs of women seeking treatment for substance abuse.

Both of these women also bring up another point -- the first explicitly, and the second implicitly. They point out that 90 days may not be enough time to overcome a substance abuse problem. This makes intuitive sense; when one has been addicted to drugs or alcohol for years, how can a few months make a substantial difference? However, more lengthy treatment programs are even more cost-prohibitive; not just in and of themselves, but in the lost work time they represent.

Solutions to this problem include the existence of comprehensive, effective aftercare models -- both ones that are professionally-run and those that are self-help in nature. Other solutions include the network of support described earlier as a way to improve the overall social supports for women in recovery, as well as the creation of more halfway and transitional housing options so that women don't have to return abruptly to the lives they had before -- and, therefore, to the temptations to use that probably still exist.

This last concern is echoed in the words of one woman who has other concerns as well:

INPT- I always have a fear of getting back on the streets and relapsing. I don't hear them talking about what to do when you think you are going to do. What to do when you return on the streets and your old friends comes around. I

don't feel I am strong enough to turn them down. I think to design a program would also include a 24 hour shelter for women who fear going back on the streets. I could have used more parenting classes as well. Knowing what to do with my kids when I relapse.

It is probable that this woman's counselors do indeed talk at least a bit about what to do post-program. However, apparently, not enough. This is understandable when taking into consideration the perspective of the women in the program. For quite possibly a very long time -- perhaps even their entire lives -- many of these women have existed in unsafe environments, including living in part or entirely on the streets. It is hard to imagine such a life unless one has lived it. Suffice it to say that compared to the safety of a nurturing treatment program, life on the streets (beyond the appeals it holds for many) represents something to fear.

Her idea about offering a shelter for women who come out of the program makes sense, although ideally it would be more than just a shelter, and would be more like a full-service transitional housing arrangement. The women could return to their jobs and (non-using) friendships, as well as take some time to build up more healthy support networks, with much less fear of returning to their addictions. In part, a full-service transitional housing arrangement is important because of obvious practical reasons such as what this woman mentions (i.e. things like old friends coming around and tempting newly recovered

substance abusers to return to their addictions). Such an arrangement would help address fear that is an emotion that cries out for comfort. If healthy sources of comfort have not been fully developed, it will be that much easier for the women to return to their addictions. If instead they have a safe place to live, with a support system in place until they can create their own, that fear is gone and it is easier to stay in recovery.

One woman's statement also expressed an interest in more parenting classes. It makes sense to interpret this comment also along the lines of having more time and experience learning about parenting. The comments in the next woman's statement indicate a desire for more parenting guidance. This brings the discussion back, in some ways, full circle to the issue of children:

INPT- I think more parenting classes would have been helpful for me. I am a young mother and kids don't come with instructions. I want to know more about how a kid develops and what to expect and treat a child at the age level. I also have a kid that wants to see and know it's father. But the father wants nothing to do with him. So I feel there should be counseling sessions for kids as well.

Even a full twelve-week round of meetings specifically about parenting is not enough to fully transmit enough knowledge about the subject so that women with low-level skills in this

area can feel confident enough to raise their children in a more healthy way. Perhaps an on-going parenting class outside the treatment facility -- even one that is self-help in nature -- would be a relatively easy alternative to these women who all of a sudden have to be on their own raising their children.

Consideration is given one to the idea of putting women who are mothers in touch with other mothers who have successfully completed the program. Undoubtedly, these women have also experienced worries and overcome obstacles to parenting in recovery. They can help the newer women to deal with some of the challenges of parenting while clean, while at the same time bolstering their own recovery.

The statement above also makes a new point. While the mothers have a definite need for help, so do their children. This can help break the cycle of addiction. Research shows that a family history of substance abuse is a strong predictor of future abuse, especially for women. While some hold that genetics are entirely to blame, there are many who perceive an environmental factor at work as well. Besides, even the most genetically-oriented theorists agree that a proper environment can counteract genetic tendencies.

Therefore, if intervention can be obtained early, these children will stand less of a chance to grow up and abuse substances themselves. Such intervention is critical, not just for their own sake, but for the sake of the women as well. Recall the comments of the woman who said that her son was using and selling drugs. This is certainly one of the many things in

her life that is making it harder for her to stop using. If one's children can be trusted to stay clean, it goes a long way in helping the parent to stay clean.

It would certainly not prove to be too much of a difficult matter to form a group for the children of the women in treatment -- especially for those women who are in treatment programs like Austin Recovery where they have their children with them. About five hours a week of time for one of the staff members would be sufficient to form, manage, and run such a group. In addition, it would give the children something else to do -- something particularly constructive -- while their mothers were having group therapy or individual sessions.

Putting all of these ideas together (both those of the researcher in examining the comments of the women as well as the direct ideas of the women themselves), one can see an overall treatment model begin to emerge. First of all, the model would be primarily designed and staffed by women to ensure that all women, especially those with past histories of abuse or victimization, feel safe and understood. There would, however, be some male staff members in order to help facilitate the learning process about what men can be trusted and how to read the signs.

The facility itself would also be designed with beauty and comfort in mind. This does not mean \$1,200 couches and room designs by professional interior decorators. It means, however, that the place would be easy to keep clean, painted and arranged with pleasant, healing colors, and full of the natural beauty of

plants and other healing things. It also means that the refrigerator would be stocked with healthy, delicious foods that the women could eat; and as petty as it might sound, traditional comfort foods like mashed potatoes couldn't hurt.

More importantly, the model would offer a wide variety of options under its umbrella. In other words, it would be a multifaceted model containing many components that women could choose from among and put together to, in effect, create their own custom treatment programs. These options would include (but not be limited to):

1. Childcare. This is a most critical element. The women would furthermore have two choices here. They could have the children with them in the actual program, or else they could place them in foster care with women who had already successfully gone through the program and are still clean. The choice of option would depend upon a variety of factors, including how distracting the children would be and what level of intense attention the women needed to pay to her own issues.

2. Attention to issues of past abuse, both childhood abuse and adult victimization: This is also critical, and would include the presence of specially trained therapists as well as an overall paradigmatic approach that validates the pain and long-lasting effects of such traumas. Some treatment models, such as the traditional AA and NA approaches, would need to be modified to accommodate women who are survivors of abuse. (There are plenty of such

modified models from which to choose, including 13-step models designed specifically by feminists.)

3. Attention to global emotional and mental health issues. This ties in with the last point, and can be as simple as what Austin Recovery does: the inclusion of weekly support groups that deal with a variety of issues women struggle with, from sexuality to low self-esteem.

4. Social support networks. While treatment programs cannot create support networks for women, they certainly can facilitate them. These networks can be facilitated by providing newly-admitted women with lists of women who "graduated" from the program in the past, as well as organizing periodic social functions in which women could meet each other and, ideally, form their own relationships. An ideal treatment model would also include a perspective

on the bigger picture. Issues of racism and classism cannot be dealt with solely on an individual (or even agency-level) basis. These are systemic issues, ones that require both intensive examination and extensive overhauls. There is no reason why advocacy for social justice issues cannot be a part of a treatment model. Indeed: such a component would probably be a wonderful way for the women to engage in healing work that goes beyond themselves and, therefore, helps keep their focus on recovery. It is true that non-profit organizations cannot directly support candidates. However, there is so much more work

to be done than this one prohibited activity, such as speaking with congress people and meeting with city officials (for example).

Alternative, barrier-free treatment models would also ideally be a source of information for other, more traditional, models. If the more male-identified programs could be transformed into more female-friendly places, this would go a long way in overcoming barriers to treatment for women, if only because more positive sources of help would exist.

Interventions for substance-dependent women are constantly challenged to successfully meet the needs of these women. The findings of this study suggest that future research should employ working models that specifically address the needs of these women. Agency and other model programs can build on women's experiences to intercede effectively in planning and supporting women through recovery. The inclusion of women in substance abuse treatment programs as a primary contributor in all stages of the design, implementation or improvement of programs designed to benefit them, might encourage those who work in treatment facilities to focus on how other women can initially recognize barriers to services and they can overcome them.

The inequality and the inappropriateness of treatment available to women prompt my suspicion that most treatment

programs were not dealing well with women, basically due to not recognizing the gender-specific issues that women were dealing with. Treatment programs for women have considered addiction as the primary problem and did not deal with the underlying social contexts. It is therefore possible that model of identifying as the primary problem might be inadequate for men as well as women, although my findings cannot determine this since I only interviewed women. Future studies may explore whether men are impacted by or share some of the same problems that seem gender-specific to women. If treatment is to be adapted and developed appropriately for women or men, it would seem important to obtain as clear a picture as possible of the anxieties, fears and practical problems which militate against help-seeking and of the needs for help which finally prompt action resulting in contact with a service. To what extent are men less likely to report difficulties in asking for help possibly fearing that in some way, the admission of their addiction would compromise their masculinity? This raises the notion of gender socialization and the specific message and practices concerning the nature of being male in society. Socialization consists of the experiences and events that boys and men encounter in order to become "members" of the ideology of masculinity (Dawson, 1996). Being a boy means adhering from an early age to many behaviors and attitudes deemed as masculine. This code of

behaviors and attitudes changes psychological functioning and changes boys' and men's inherent ways of being with other people. For this reason, researchers assert that "being male" is defined by social constructs in our culture and society. Furthermore, boys and men are socialized and taught to avoid shame at all costs, to wear a mask of coolness, to act as though everything is going all right, as though everything is under control, even if it is not. This leads many boys and men to push themselves excessively at academic or career-related work, often in an effort to repress feelings of failure or unhappiness. Perhaps the most traumatizing and dangerous concept thrust on boys and men is the literal gender straitjacket that prohibits boys from expressing feelings or urges that seem (mistakenly) to be "feminine," for example, dependence, warmth, and empathy (Dawson, 1996). Rather than being allowed to explore these emotional states and activities, boys are prematurely forced to shut them out, to become self-reliant. When boys begin to behave differently, they are usually met not empathetically, but with ridicule, with taunts and threats that shame them for their failure to act and feel in stereotypically "masculine" ways. As a result, boys learn to change their behavior and never to act that way again (Schober and Annis, 1996). The aforementioned are some of the examples of how male gender role socialization is linked to shame and the shutdown of emotional and communicative

coping capacities in males. The fact that more men are seeking help represents a challenge for counselors to find ways to make treatment not only palatable but also effective for them. Future research can look at ways in which men can benefit from treatment by (a) understanding the strong connection between their beliefs about gender and their problematic behaviors (b) change their "reality" about the meaning of masculinity to a more functional one, (c) recognize their emotional needs and accept them as basic, (d) understand their need for connectedness and find ways to connect, and (e) understand the influences of the family of origin on them and their beliefs and be able to differentiate themselves in healthy ways. This primary goal is to help men broaden their beliefs about what it means to be male. Therefore if beliefs broaden, behavior is likely to follow suit. Future research is needed to establish and locate the sources of problems in the interpersonal, familial, and societal environments in which men develop as human beings. The counseling community can prepare itself and become informed and capable of providing the counseling that men need and deserve.

Future research is essential for an expanded understanding for both men and women's addiction for creating effective treatment. Based upon empirical research that suggests addicted women are vastly underserved in this country,

appropriate interventions are imperative. Successful treatment must provide a corresponding complexity of intervention ranging from the intrapersonal to the interpersonal to the environmental to form a holistic package of services that is based on the needs of the individual.

If women are to enter treatment freely, treatment centers must be equipped to admit them and their children. Furthermore, these interventions must be provided in agencies that women frequent, such as mental health facilities, shelters and public health departments--- not just in specialized facilities. Whether aimed at women as individuals or as individuals in their environments, interventions must be infused with empowerment. Therefore, treatment must focus on women's strengths, rather on their deficits, and women should be actively involved in the creation of intervention. The involvement of women presents ongoing opportunities to practice problem solving and decision making that, in turn, will increase women's competence and self-esteem, both of which guarantee ongoing success in recovering from their addiction.

## APPENDIX A

### INDEPTH INTERVIEW GUIDE

The questions in Part I are designed to give the researcher a general idea about the informant, her situation and experiences, and her perceptions. The questions in Part II are narrower and address specific barriers to treatment. They may serve as a springboard for further questions about the barriers and how they were overcome by the in-treatment and aftercare subgroups. Part III contains the demographic items necessary to evaluate the interconnected variables of gender, race, ethnicity, and class. It is necessary to ask many of the same questions to all three groups; therefore, rather than setting out three distinct guides, parentheses have been used to denote the group-appropriate change in tense. Separate sections that pertain specifically to each subgroup are designated as such.

#### Part I

1. How would you describe your current family situation?  
Are you married? How long?  
Do you have a boyfriend/partner? How long with that person?  
Do you have children? How many? How old?
2. How would you describe your life at home?
3. What was your life like as you were growing up?
4. How do you see yourself? What words would you use to describe yourself?
5. Is that different from the way you would have described yourself in the past?  
How?
6. How do you think other people see you now? What words would they use to describe you?
7. How would you describe your health?
8. What was (is) the substance(s) that you have a problem with?
9. Why did alcohol become the problem and not some other drug? [Question in reverse if the addiction is to drugs.]
10. How old were you when you first started using \_\_\_\_\_?
11. Before \_\_\_\_\_ became a problem, how would you describe your normal day?
12. When did \_\_\_\_\_ become a problem?
13. Describe what was going on in your life then?
14. How often, how much, did (do) you drink/use daily?
15. When did you know that \_\_\_\_\_ was a problem?  
What happened to make you realize it?
16. After \_\_\_\_\_ became a problem, how would you describe your normal day?
17. Were there (have there been) any negative consequences associated with your \_\_\_\_\_?  
What were (are) they?

- What happened?
18. Did (does) \_\_\_\_\_ give you pleasure/good feelings?  
When?  
Why?
  19. Did (do) you use more \_\_\_\_\_ at particular times or in particular situations?  
What were (are) the circumstances?  
Why did (do) you drink/use then?
  20. Did (have) you ever try to stop drinking or using drugs on your own?  
Why or why not?  
If yes, what did you do?  
What were the results?  
How did that make you feel?
  21. Did (have) you ever seek (sought) treatment for the problem in the past?  
Why or why not?  
If yes, what did the program offer you?  
What were the results? (Completed program/dropped out/relapsed?)  
How did that make you feel?  
If dropped out, what might have kept you in the program?  
What do you think would have made the program better?  
Why?  
    Child care? Social support? Group/family workshops?  
    Education counseling?  
How did the staff treat you?  
Why do you think that was?  
How were you treated by other program participants?  
Why do you think that was?
  22. How will (would) your life be different without \_\_\_\_\_?
  23. How will (would) stopping affect the lives of others important to you?
  24. How will (would) you feel about these changes?
  25. If you were to design a treatment facility especially for women, what would you offer?  
What do you see as the important needs of women entering treatment?

**THE FOLLOWING ARE SPECIFIC TO THE NONTREATMENT GROUP**

26. Have you ever said to yourself “I should stop”?
27. Why do you use \_\_\_\_\_?  
How do you feel when you use \_\_\_\_\_?  
How do you feel when you don’t use \_\_\_\_\_?
28. Do you want to stop?  
Why or why not?
29. Have you ever asked yourself why you don’t get treatment (or didn’t stay in treatment)?  
What is the answer?
30. Have others asked you why don’t get treatment (or didn’t stay in treatment)?

- How have you answered them?
31. What are your greatest concerns/fears about your continued use of \_\_\_\_\_?  
What would help you overcome them?
32. How do you see yourself as a mother?  
A partner?  
A worker?

**THE FOLLOWING ARE SPECIFIC TO THE IN-TREATMENT AND AFTERCARE GROUPS**

33. What made you decide to seek treatment?  
How did you learn about Austin Recovery?  
What did you know about Austin Recovery before entering treatment here?
34. How long (were) have you been here?  
(How long have you been out of the program)?
35. How did you end up at Austin Recovery?  
Why did you come here?
36. Did the program offer anything that you especially needed or could benefit from?  
What?  
How did that make you feel?  
Did the program live up to your expectations?  
Why or why not?
37. Has (did) the program helped you?  
How?  
How could it be made better?  
How are (were) you treated by the staff?  
How are (were) you treated by the other residents?
38. How are you dealing with your addiction now?
39. How does (did) treatment change your understanding of your use of \_\_\_\_\_?
40. Where were you living before you came here?
41. Where will you live when you leave the center?  
(Where are you living now?)
42. What concerns/fears do you have now about your addiction?
43. What are your expectations of the future?
44. How do you see yourself now as a mother?  
Partner? Worker?  
Are these different than the way you saw yourself in the past?

**Part II**

- A. Role as Mother
1. [If children] Are your children in your custody?
2. Did (do) they know about the problem you have with \_\_\_\_\_?

- Why or why not?  
If yes, how?
3. How did (does) your \_\_\_\_\_ affect them?  
How did (do) you feel about that?
  4. Were you pregnant while \_\_\_\_\_?  
If yes, did that concern you?  
Why or why not?  
Did you do anything about your \_\_\_\_\_ at that time?  
Why or why not?
  5. Did (does) having children affect your seeking treatment in any way?  
How? Why?

**THE FOLLOWING ARE SPECIFIC TO THE IN-TREATMENT AND AFTERCARE GROUPS**

6. Who cares (cared) for your young children now (while you were in treatment)?
7. Did finding child care interfere with your ability to enter treatment?
8. How did you overcome this problem?
9. What would you advise other women to do about child care so they can get help for their drinking or drug use?

**B. Social Stigma, Negative Self-Perceptions, and Depression**

10. What are your parents' general attitudes toward heavy drinking/drug use?  
What are their attitudes about women who use \_\_\_\_\_ heavily?
11. What are your husband/boyfriend's general attitudes about them?  
What is his attitude about women who use \_\_\_\_\_ heavily?
12. What are your friends' attitudes about them?  
What are their attitudes toward women who use \_\_\_\_\_ heavily?
13. What are your own feelings about women who are heavy users of \_\_\_\_\_?  
Were there any changes in your feelings after \_\_\_\_\_ became a problem for you?  
What were those changes? Why did they occur?
14. Did (do) others know you have a problem with \_\_\_\_\_?  
If no, how did (do) you keep it from them?  
Why did (do) you keep it from them?  
If yes, how did (do) they know?  
How long after \_\_\_\_\_ became a problem did they know?
15. How did (do) you feel about yourself while \_\_\_\_\_?  
Why did (do) you feel that way?  
Did (do) these feelings trouble you?  
Why or why not?
16. Did (do) these feelings keep you from seeking treatment?  
Why or why not?
17. How did (can) you overcome these feelings and get help for your drinking or drug use?
18. Have you ever felt 'blue' or down for weeks or months at a time?  
If yes, when did it begin?  
What are those feelings like?  
What happens when you feel that way?

19. Have you ever felt like you are worthless or bad?  
If yes, when did these feelings begin?  
What do you think causes them?  
What happens when you feel that way?
20. Have you ever thought about killing yourself?  
If yes, when do you feel like that?
21. Have you ever tried to get help for any of these feelings?  
Why or why not?  
If yes, how? Who did you go to for help?  
What were the results?
22. Which problem is more troubling to you: feelings of being down/worthlessness/sadness/suicide or substance abuse?  
Why?
23. Have you ever been diagnosed by a doctor or mental health worker as an alcoholic/addict?  
If yes, how did that make you feel?  
What did you do about it?  
How did the doctor/social worker treat you?
24. Do you define yourself as an alcoholic/addict?  
Why or why not?  
If yes, when did that realization occur?  
How did you feel about that?

**SPECIFIC TO THE NONTREATMENT GROUP**

25. You've indicated some negative feelings held by yourself or others (reflect back which).  
Could a treatment program that offered you help with these feelings be valuable to you?  
How?

**SPECIFIC TO THE IN-TREATMENT AND AFTERCARE GROUPS**

26. Did Austin Recovery help with you your negative feelings?  
How?
- C. Abuse, Victimization
27. How would you describe your relationship between you and your parents when you were a child?
  28. Did any member of your family have a problem with alcohol or drug use when you were growing up?  
If yes, who?  
How did you know?  
How did it affect their behavior toward you?  
How did you feel about that?  
How did you feel about them?
  29. When you were a child did anyone ever mistreat you in any way?  
How? (Emotionally, physically, sexually)  
Who?

- Why?  
 How did that make you feel then?  
 How does it make you feel now?
30. Were you ever raped or sexually assaulted at any time in your life?  
 By whom?  
 How did it make you feel at the time?  
 How do you feel about it now?
31. Have you ever been abused or beaten by a boyfriend or husband?  
 How did that make you feel at the time?  
 How do you feel about it now?
32. Does your husband/boyfriend/partner use \_\_\_\_\_?  
 Has \_\_\_\_\_ been a problem for him also?  
 If yes, how often does he get drunk/high?  
 How does it affect his behavior?  
 How does it affect his feelings for you?  
 How does it affect your feelings for him?
33. Did (could) overcoming these feelings affect your life?  
 In what way?
34. How did (do) you deal with the feelings connected to mistreatment/rape/beatings?

**SPECIFIC TO NONTREATMENT GROUP**

35. Could a treatment program that helped you deal with these feelings be useful to you?  
 How?

**SPECIFIC TO IN-TREATMENT AND AFTERCARE GROUPS**

36. Did Austin Recovery help you deal with these feelings?  
 How?

**D. Social Support**

37. What does being close to another person mean to you?
38. Are you close to members of your family?  
 Who?
39. Are you close to your husband/partner?  
 How would you describe your relationship?
40. Do you have close friends?  
 How would you describe those relationships?
41. Can you turn to your family members/husband-partner/ close friends for help?  
 Who? Why that person?
42. Did (does) anyone in your family know about your problem with \_\_\_\_\_?  
 If no, why don't they know?  
 If yes, how did (do) they react?  
 Did it change the way they felt about or acted toward you?  
 How?  
 Did (do) they want you to get help?  
 Why or why not?
43. Did (does) your husband/partner know?  
 If no, why not?

- If yes, how did (does) he react to your problem?  
 Did it change the way he treated you or felt about you?  
 How?  
 Did (does) he want you to get help?  
 Why or why not?  
 Did (does) he ever encourage you to \_\_\_\_\_?  
 If yes, what were (are) the circumstances?
44. Did (do) your friends know?  
 If no, why don't they know?  
 If yes, did (does) it change their behavior and feelings toward you?  
 Why or why not?  
 Did (do) they want you to get treatment?  
 Why or why not?  
 Did (do) they ever encourage you to \_\_\_\_\_?  
 If yes, what were (are) the circumstances?
45. [If subject has not been discouraged from drinking or actively encouraged to drink] What helped (might help) you to overcome this influence and enter treatment?

**THE FOLLOWING ARE SPECIFIC TO THE IN-TREATMENT AND AFTERCARE GROUPS**

46. How do others feel about/act toward you now?  
 47. What has this meant to you?  
 48. Did the treatment program here help others to see you in a different way? How?

**THE FOLLOWING ARE SPECIFIC TO THE AFTERCARE GROUP**

49. How has the aftercare program helped you?  
 50. Are you involved in a support network?  
 Why or why not?  
 51. Are you still involved in the 12-step program?  
 Why or why not?  
 52. Since leaving the program, do you spend time with other who use \_\_\_\_\_?  
 Why or why not?  
 If yes, how do you deal with that?  
 53. Have you gotten any grief from anyone about being sober?  
 Who?  
 How do you handle this?  
 Why do you handle it that way?  
 54. What have you learned about yourself since being back in the community?  
 55. Have you slipped?  
 If yes, how did you feel about that?  
 What was going on in your life at the time?  
 How long did it last?  
 How did you pull out of it?

Did others help?  
Who?  
How?

**FOR ALL**

56. Earlier in the interview, I asked you: If you were to design a treatment facility especially for women, what would you offer? What do you see as the important needs of women entering treatment? Would you like to change or add anything to your answer.
57. Is there anything else regarding your problem with \_\_\_\_\_ that's important to you that we haven't discussed?

**Part III.**

**Demographics**

Age?  
Level of education?  
Employment/source of income?  
Amount of income?  
Insurance? What type?  
Place of residence?  
Race? (This is not always apparent.)

## APPENDIX B



### University of Pittsburgh Institutional Review Board

Exempt and Expedited Reviews  
Christopher M. Ryan, Ph.D., Vice Chair

Multiple Project Assurance: M-1259

3500 Fifth Avenue  
Suite 105  
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Phone: 412.578.3424  
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TO: Francine Bush  
FROM: Christopher M. Ryan, Ph.D., Vice Chair *Chris*  
DATE: September 16, 2003

PROTOCOL: Barriers to Treatment: An Ethnographic Study of Substance-Dependent Women Seeking Treatment

IRB Number: 0307039

The above-referenced protocol has been reviewed by the University of Pittsburgh Institutional Review Board. Based on the information provided in the IRB protocol, this project meets all the necessary criteria for an exemption, and is hereby designated as "exempt" under section 45 CFR 46.101 (b)(2).

The regulations of the University of Pittsburgh IRB require that exempt protocols be re-reviewed every three years. If you wish to continue the research after that time, a new application must be submitted.

- If any modifications are made to this project, please submit an 'exempt modification' form to the IRB.
- Please advise the IRB when your project has been completed so that it may be officially terminated in the IRB database.
- This research study may be audited by the University of Pittsburgh Research Conduct and Compliance Office

Approval Date: 09/16/2003  
Renewal Date: 09/16/2006

CR/ky

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