

Helping Women Recover: A Comprehensive Integrated Treatment Model

By

Stephanie S. Covington, Ph.D., L.C.S.W
Institute for Relational Development
Center for Gender and Justice

Alcohol Treatment Quarterly Vol. 18, No. 3, 2000

Abstract: This article offers a brief overview of the treatment history of women's addictions. It then provides a new model for treating women (the *Helping Women Recover* program) that incorporates three theories: theory of addiction; theory of women's psychological development; theory of trauma. The structure and content of this gender-responsive treatment program is also discussed with a focus on four areas: self, relationship, sexuality, and spirituality. *Helping Women Recover* is designed to be used in both community-based and criminal justice-based programs for women.

INTRODUCTION: HISTORY OF THE TREATMENT OF WOMEN'S ADDICTIONS

The issue of women's addictions is not new, but until recently it has been characterized by silence. It was not openly discussed, even by those in the field of addiction recovery, until the late 1960s. Before then chemically dependent women were, in essence, invisible (Sandmaier, 1992).

That invisibility was largely attributable to strong social taboos against women's use of alcohol and other drugs. In fact, in the United States it was illegal to show a woman drinking in a movie or advertisement until the 1950s. This was not because women did not drink, but because people did not want to see women drinking. It is still true that families exhibit much more denial about the substance abuse of their sisters, mothers, and daughters than they do about that of male family members.

Even after the advent of Alcoholics Anonymous in the 1930s, treatment programs and research focused on male alcoholics and addicts. Alcoholics Anonymous (AA) was highly effective for male alcoholics and became the standard for many kinds of mutual-help recovery groups. Eventually women joined AA and participated in a program designed by men for men, and the fact that many of them have recovered has made it difficult to question the efficacy of AA's approach for women and to investigate the need for gender-specific treatment.

The practical experience of AA became one of two cornerstones on which addiction treatment programs were based in the U.S. The second was the research analysis of E.M. Jellinek, whose model of how people recover from alcoholism became known as the "Jellinek curve." Information pointing to the possible limitations of both approaches--AA's and Jellinek's--for women came in 1945, when *The AA Grapevine* mailed 1,600 questionnaires to recovering alcoholics, asking them to describe the processes of their addiction and their recovery. Replies were received from only 158 people. As the response rate was so low, Jellinek questioned the

validity of the findings and subsequently was hired by AA to analyze and interpret the data.

Jellinek discovered that the respondents diverged dramatically into two groups: Ninety-eight respondents described their addiction and recovery in one way, while fifteen described theirs in a very different way. (The remaining forty-five questionnaires were improperly filled out and could not be used.) The larger group was all male, and the smaller group was all female. Because the sample of fifteen women was too small to analyze separately and because their information "differed so greatly" from that of the men (Jellinek, 1946, p. 6), Jellinek threw out their responses and based his model entirely on the men's data. No further investigation was made to see whether females indeed followed a distinct pattern of addiction and recovery or needed a distinct model for treatment. In other words, both of the cornerstone treatment approaches used in the U.S. have been based exclusively on the experiences of men.

Then in the 1960s and 1970s many women began to join consciousness-raising groups, where they found a forum for discussing previously taboo subjects, including incest and domestic violence as well as the use of alcohol and other drugs. Eventually, in 1976, the U.S. Congress responded to pressure from feminist organizations and alcohol and drug constituency groups with legislation that funded specialized women's treatment for the first time. Meanwhile, the National Council on Alcoholism created a special office on women. The programs launched by these initiatives laid the foundation for an understanding of treatment for women (Galbraith, 1994). These programs demonstrated that women would seek and pursue treatment when it was *holistic* (addressing a broad range of needs, including sexuality, violence, and life-management skills), *humanizing*, *long term*, and *child friendly*--in short, when it was tailored for females.

In the succeeding years, clinicians and researchers have built on these initial findings and have developed a solid body of knowledge in best practices for the treatment of women. Research now indicates that addiction treatment programs that address women's unique needs--such as their relationships with their partners, families, and children as well as any history of physical and sexual abuse--are more effective for women than traditional programs (Carten, 1996; Center for Substance Abuse Treatment, 1994; Covington, 1998a; Finklestein, 1993).

These research findings have made it possible to design successful treatment programs especially for women. This paper presents a new integrated model for women's treatment based on theory, clinical experience, and the basic principle of knowing who each client is and what she brings to the treatment setting.

A NEW TREATMENT MODEL: THEORETICAL INTEGRATION

Any programs designed for treating women need to incorporate the body of knowledge developed thus far. We know that female addicts often have histories that include three elements, (1) substance abuse since early adolescence, (2) developmental delays caused by damaging relationships, and (3) multiple traumas (including physical and/or sexual abuse, poverty, and racism). The model described in this paper integrates three theories, (theory of addiction, theory of women's psychological development, theory of trauma), to create a foundation for working with the realities of women's lives (Covington, 1999).

Theory 1: Addiction

Disease versus Disorder

For generations, addiction was viewed as a sign of lapsed morals (Sandmaier, 1992). In the

1950s, however, mental health professionals proposed an alternative model of viewing addiction as a sign of an underlying psychological disorder, such as a death wish, a fixation at the oral stage (as described by Freud), or a "sociopathic personality" (Brown, 1995, p. 13). If one could somehow resolve the underlying disorder, then the addiction would disappear.

During those same years, the chemical dependency field was born. Its practitioners advocated viewing addiction not as a symptom, but as a primary condition with its own symptoms and without moral stigma. The condition could not be managed through will power; instead, the afflicted person needed to make lifestyle changes to achieve emotional and physical stability. These practitioners further proposed that the disease of addiction included not only physical characteristics, but also emotional and spiritual dimensions.

Since its inception, this theory has gained wide acceptance. In the 1990s, practitioners of mental health and of chemical dependency began to consult with and learn from one another. At the same time, health professionals in many disciplines began to revise their concepts of disease; many developed a holistic view that every disease includes not only physical, psychological, emotional, and spiritual characteristics (Northrup, 1994), but also environmental and sociopolitical aspects.

One way to understand addiction as a disease is to compare it with cancer. Both vary greatly from one afflicted individual to another. Both have a physical dimension that includes a genetic component. Cancer and addiction also have certain emotional and psychological dimensions in common. Stress and unhealthy ways of handling it can increase not only the risk of developing cancer, but also the risk of turning to alcohol or other drugs. Cancer and addiction share certain sociopolitical dynamics as well. For example, both carcinogenic products and addictive substances generate huge profits, despite their deadly potential.

Even though they share a number of characteristics, cancer is universally acknowledged as a disease but addiction is not. Addiction is often treated as a crime (the "disorder" model). One factor that has perpetuated the "disorder" model is an important aspect of the "disease" model: *An addict acknowledges loss of control*. In Western culture, control is highly prized; the organizing principle of life is the individual's pursuit of power and self-control.

The debate over models will probably continue, but the disease model offers a more helpful way to approach the treatment of addicts. The disorder model focuses on social-learning theory and a cognitive-behavioral approach to treatment (Parks, 1997), thereby ignoring information gained from genetic studies, the affective aspects of the problem and its solution (Brown, 1985), and the sociocultural and environmental elements involved. The holistic disease model allows clinicians to treat addiction as the primary problem while also addressing related issues of genetic predisposition, health consequences, shame, isolation, and/or a history of abuse.

Research on Women versus Research on Men

The research involving male addicts differs in some ways from those involving female addicts; consequently, research has yielded different types of data as well as informational gaps. For example, numerous studies have examined the link between alcoholism in fathers and sons, clearly indicating a genetic link in men. Few studies, however, have concentrated on the genetic link in women.

Environmental and psychosocial factors in women's addictions have been much more

thoroughly studied than genetic factors (Finkelstein, Kennedy, Thomas, & Kearns, 1997). *Stigma*, or severe social disapproval, is the main psychosocial issue that distinguishes the substance abuse of females from that of males. While drinking-related behavior is often seen as "macho" in men, it conflicts with society's view of femininity and especially with the roles of wife and mother. Women often internalize this stigma. They often feel guilt and shame--sometimes even despair and fear--when they are addicted to alcohol and other drugs. Mothers also know that addiction may cause them to lose their children. This stigma and the threat of severe consequences often lead to *denial*, or minimizing the impact of substance abuse, on the part of women and their families. When a woman does not seek treatment, denial is often the reason.

When a woman is in denial, the clinician's task is to break through her denial so that she can shift her perceptions in two ways: (1) from believing "I am in control" to believing and admitting "I am not in control" and (2) from believing "I am not an addict" to believing and admitting "I am an addict" (Brown, 1985, p. 34). To facilitate these shifts in perception, the clinician needs to understand how women grow and develop psychologically and how trauma affects addicted women.

Theory 2: Women's Psychological Development

Growth-Fostering Relationships

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

Miller challenged the assumption that separation was the route to intimacy. A woman's primary motivation, she said, is to build a sense of connection with others. Women develop a sense of self and self-worth when their actions arise from and lead back to connections with others. Connection, not separation, is the guiding principle of growth for women.

Miller's work led to the creation of the Stone Center at Wellesley College, whose purpose was to explore the qualities of relationships that foster healthy growth in women. According to the Center's "Relational Model," true connections are *mutual, empathic, creative, energy-releasing*, and *empowering* for all participants. Such connections are so crucial for women that women's psychological problems can be traced to disconnections or violations within relationships--whether in families, with personal acquaintances, or in society at large (Miller, 1986).

Mutuality means that each person in a relationship can reveal his or her feelings, thoughts, and perceptions and can both move with and be moved by the feelings, thoughts, and perceptions of the other. Each person and the relationship itself can change and move forward because there is mutual influence and mutual responsiveness.

Empathy "is a complex, highly developed ability to join with another at a cognitive and affective level without losing connection with one's own experience" (Covington & Surrey, 1997, p. 336). An empathic person feels personally authentic in the relationship and feels that he

or she knows the other.

Mutuality and empathy empower women, not with power *over* others but with power that is used *with* others. As a result of mutuality and empathy, women feel more able to share power for constructive, creative ends. Mutual, empathic relationships not only foster growth, but also bestow on all participants (1) increased zest and vitality, (2) empowerment to act, (3) knowledge of self and others, (4) self-worth, and (5) a desire for greater connection (Miller, 1986). Consequently, *Helping Women Recover*, the treatment program discussed in this paper, is designed to foster mutual, empathic relationships both among women participating in the program and between treatment providers and the women.

Addiction and Relationships

From the perspective of the Relational Model, some women use alcohol and other drugs in order to make or keep connections. Finkelstein (1993) suggests that designers of programs for addicted women need to take into account (1) past family relationships, (2) current family relationships, and (3) relationships with friends and partners, and (4) relationships developed within the treatment context.

For example, researchers have identified five ways in which relationships with male partners can contribute to women's substance abuse and hinder their recovery. First, male partners often introduce women to drugs. Many women start using substances in order to feel connected with addicted lovers, or they drink because their boyfriends urge them to. Second, whether or not a male partner first encouraged a woman's drug use, he often is her supplier once she is addicted. Third, addicted women's lives are full of men who disappoint them, do not provide for their children, and go to jail. These women long for the fathers of their children to provide emotional and financial support, but such longings often lead to disappointment and solace in drug use. Fourth, many women report experiencing physical abuse from the men in their lives. Drugs help numb the pain of violent relationships that are also lacking mutuality and empathy. Fifth, studies suggest that women receive less support from their partners for entering treatment than men receive from theirs (Amaro & Hardy-Fanta, 1995).

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

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

Addiction is a relationship that constricts a woman's life. The task in helping a woman to recover, then, is to help her transfer her need for relationship to sources of growth-fostering connections.

Theory 3: Trauma

Because addicted women have a high rate of abuse in their lives, a gender-specific treatment

program needs to address trauma. In the U.S. approximately 1.8 million women are abused each year. A history of trauma drastically increases the likelihood that a woman will abuse alcohol or other drugs. It also increases the likelihood of interaction with the criminal justice system (Covington, 1998b). Addicted women are likely to have been abused sexually, physically, and emotionally by more perpetrators, more often, and for longer periods of time than their nonaddicted counterparts (Covington & Kohen, 1984).

Furthermore, trauma is not limited to suffering violence firsthand; it includes witnessing violence as well as being stigmatized because of race, poverty, incarceration, or sexual orientation. Thus, in treating addicted women, clinicians must understand that they are also probably treating trauma survivors. Although they do not need to be experts in trauma recovery, they do need to be aware of its three basic stages, as outlined by Judith Herman (1992) in *Trauma and Recovery*: (1) safety, (2) remembrance and mourning, and (3) reconnection. Stage 1 focuses on caring for oneself in the present (a twelve-step group, for example). Stage 1 groups should be homogenous. Stage 2 focuses on the trauma that occurred in the past (a survivors' group, for example). Participants tell their stories of trauma and mourn their old selves, which the traumas destroyed. Stage 3 focuses on reconnecting with the world--in essence, developing a new self and creating a new future (psychodynamically-focused psychotherapy groups, for example). Stage 3 groups are traditionally unstructured and heterogeneous.

Stage 1 is the stage that most concerns treatment providers of the program described in this paper. On entering treatment, a woman typically is in Stage 1, and her primary need is safety. Clinicians can help women to feel safe by ensuring as much as possible that the environment is free of physical and sexual harassment and by assessing each woman's risk of domestic violence at home. They also can teach women to feel safe *internally* by using self-soothing techniques rather than alcohol or other drugs to alleviate depression or anxiety.

Herman emphasizes that a trauma survivor who is working on safety issues needs to be in a homogeneous recovery group (composed solely of women), and the facilitator should be female. The reasoning is that women may not want to talk in depth about physical or sexual abuse in groups that include men until they are ready for Stage 3.

AN EFFECTIVE TREATMENT PROGRAM

The structural and content elements of a gender-responsive treatment program are described in the following paragraphs.

Healing Environment

Women recover in an environment that facilitates healing--one that is characterized by (1) safety, (2) connection, and (3) empowerment. *Safety* means that rules of conduct provide appropriate boundaries, creating an environment that is free of physical, emotional, and sexual harassment. Although it may be impossible for clinician to guarantee safety absolutely, program participants must know that the environment is likely to be safe for them.

Connection means that exchanges between treatment providers and participants are mutual rather than authoritarian in approach and tone. The women sense that the clinician wants to understand their experiences, is fully present with them when they recall painful experiences, allows their stories to affect her, and is not overwhelmed by their stories. The clinician respects

each woman's uniqueness while affirming ways in which she and the women are alike. As this kind of mutual, empathic, respectful, compassionate connection is modeled; similar connections grow among participants.

Empowerment means that the clinician models how to use power *with* and *for* others rather than *over* them. She sets limits that are firm but respectful rather than blaming. She encourages participants to believe in and exercise their abilities, and she enables them to practice and observe one another using power appropriately.

Three Levels of Intervention

The group process and individual activities help women begin to heal on three levels (Brown, 1985): (1) affective, (2) cognitive, and (3) behavioral.

On the *affective* level, women learn to express their feelings appropriately and to contain them in healthy ways by using self-soothing techniques. Because women often become dependent on drugs in an effort to seek relief from painful emotional states, they need a safe environment in which to learn how to understand their feelings and how to work through their emotions.

On the *cognitive* level, education helps to correct women's misperceptions and distorted thinking. Participants learn a process of critical thinking in which they first consider their thoughts and feelings and then make decisions.

On the *behavioral* level, the women make changes in their drinking or drug-using behavior.

Asset Model

In traditional treatment, the clinician does a needs assessment and focuses on what the client lacks. The drawback of this model is that each woman is already struggling with a poor sense of herself as a result of factors such as her addiction, her parenting history, or her criminal justice involvement. In contrast, an "asset" model of treatment focuses on each woman's strengths; it empowers her and increases her sense of self.

In using an asset model, the clinician helps each participant to identify current strengths and skills, which will aid her in the healing process. For example, the clinician may portray one woman's relational difficulties as "efforts to connect" rather than as "failures to separate or to disconnect." The clinician repeatedly affirms participants' abilities to care, empathize, use their intuition, and build relationships. "As a woman feels more valued, her need for alcohol, tobacco, and other drugs might diminish and her resilience increase" (Finkelstein et al., 1997, p. 6).

Cultural Context and Gender

Although the program described here is designed to be gender-specific, it is important to realize that just as women's lives are different from men's lives, women's lives are not all the same. Although there are common threads in all women's lives because of their gender, the clinician must be sensitive to all of the differences among participants (for example, differences in race, class, ethnicity, sexual orientation, and age).

Four Content Areas

The Center for Substance Abuse Treatment (CSAT) has stated that the following issues are essential to address in a comprehensive treatment program (1994):

1. The process of addiction, especially related issues that are gender specific (including

- social, physiological, and psychological consequences of addiction as well as factors related to the onset of addiction)
2. Low self-esteem
 3. Racial, ethnic, and cultural issues
 4. Gender discrimination and harassment
 5. Disability-related issues, such as transportation and employment
 6. Relationships with family and significant others
 7. Attachments to unhealthy interpersonal relationships
 8. Interpersonal violence, including incest, rape, battering, and other abuse
 9. Eating disorders
 10. Sexuality, including sexual functioning and sexual orientation
 11. Parenting
 12. Grief related to the loss of alcohol or other drugs, children, family members, or partners
 13. Work
 14. Appearance and overall health and hygiene
 15. Isolation related to a lack of support systems (which may or may not include family members and/or partners) and other resources
 16. Life-plan development
 17. Child care and custody

It is not helpful to view these issues as "problems" to be solved; instead, it is better to use this list of issues to assess the "level of burden" that each woman carries (Brown, Huba, & Melchior, 1995, p. 340). This approach is one that does not exacerbate the stigma that women already feel. It also helps the clinician to understand participants, to know how to respond when a woman does not comply with treatment, and to educate staff members as well as participants' family members.

The CSAT list takes into account the physical, psychological, emotional, spiritual, and sociopolitical aspects of addiction. These seventeen issues may be grouped into four major areas: (1) self, (2) relationships, (3) sexuality, and (4) spirituality. Interviews with women in recovery indicate that these four areas reflect the major aspects of life that change during recovery and the most common triggers for relapse if not addressed (Covington, 1994). The *Helping Women Recover* program described here addresses these four areas in four separate modules.

Self Module

In this module, women discover what the "self" is; learn that addiction can be understood as a disorder of the self; learn about the sources of self-esteem; consider the effects of sexism, racism, and stigma on a sense of self; and begin to develop their own senses of themselves. They learn that recovery is about the expansion and growth of the self. This module enables them to integrate their outer selves (their roles) with their inner selves (their feelings, thoughts, and attitudes).

Relationship Module

In this module, the women explore their roles in their families of origin; discuss myths about motherhood and their relationships with their own mothers; review their relationship histories, including possible histories of interpersonal violence; and make decisions about how they can build healthy support systems. As stated previously, relationship issues are paramount in early recovery, as sometimes a woman uses addictive substances to maintain a relationship, to fill a void in a relationship, or to deal with the pain of being abused. To assist the participants' learning, the treatment providers must model healthy relationships both among themselves and with participants. Being in a community--having a sense of connection with others--is essential for continuous, long-term recovery.

Sexuality Module

In this module, women explore the connections between addiction and sexuality, body image, sexual identity, sexual abuse, and the fear of sex when clean and sober. Sexuality has often been neglected in addiction treatment, and it is a major cause of relapse (Covington, 1997). Healthy sexuality is essential to a woman's sense of self-worth. Because substance abuse often interrupts the normal process of healthy sexual development, a woman may enter recovery with developmental delays. Many also enter struggling with sexual dysfunction, shame, fear, and/or trauma that must be addressed so that they do not return to addiction to manage the pain of these difficulties.

Spirituality Module

In this module, the women are introduced to the concepts of spirituality, prayer, and meditation. Spirituality in this context deals with transformation, connection, meaning, and wholeness (Covington, 1998a)—important elements in recovery. Each woman is given an opportunity to experience aspects of spirituality and to create a vision for her immediate future in recovery. Connecting to her own definition of spirituality is essential to each woman's recovery.

CONCLUSION

All of us who work with addicted women can be grateful that so much progress has been made in the last few decades in our knowledge of addiction and our resulting ability to design and implement effective recovery programs. We can also be grateful that we have positive avenues to offer women--avenues that concentrate on their strengths, not their weaknesses.

I believe it is important for each of us to understand that we work on multiple levels when we are working with women. We work on an individual level when we do our own healing work and when we work to help another woman to recover. We also work on a political level when we help women to grow, develop and heal. This is a political act in a society that limits and devalues women. In addition, we work on a spiritual level, helping to heal the feminine energy or spirit in this world, which has been overshadowed by the masculine. With this kind of work--bringing the feminine into balance with the masculine --we contribute to the healing of our entire planet.

References

- Amaro, H., & Hardy-Fanta, C. (1995, October/December). Gender relations in addiction and recovery. *Journal of Psychiatric Drugs*, 27(4), 325-337.
- Brown, S. (1985). *Treating the alcoholic: A developmental model*. New York: John Wiley.
- Brown, S. (1995). *Treating alcoholics*. San Francisco, CA: Jossey-Bass.
- Brown, V., Huba, G., & Melchior, L. (1995). Level of burden: Women with more than one co-occurring disorder. *Journal of Psychiatric Drugs*, 27(4), 339-345.
- Carten, A.F. (1996). Mothers in recovery: Rebuilding families in the aftermath of addiction. *Social Work*, 41, 214-223.
- Center for Substance Abuse Treatment. (1994). *Practical approaches in the treatment of women who abuse alcohol and other drugs*. Rockville, MD: Department of Health and Human Services, Public Health Service.
- Covington, S. (1994). *A woman's way through the twelve steps*. Center City, MN: Hazelden.
- Covington, S. (1997). Women, addiction, and sexuality. In L.A. Straussner & E. Zelvin (Eds.), *Gender issues in addiction: Men and women in treatment*. Northvale, NJ: Jason Aronson.
- Covington, S. (1998a). The relational theory of women's psychological development: Implications for the criminal justice system. In R. Zaplin (Ed.). *Female crime and delinquency: Critical perspectives and effective interventions*. Gaithersburg, MD: Aspen.
- Covington, S. (1998b). Women in prison: Approaches in the treatment of our most invisible population. *Women in Therapy*, 21(1), 141-155.
- Covington, S. (1999). *Helping women recover* (with a special edition for the criminal justice system). San Francisco: Jossey-Bass.
- Covington, S., & Kohen, J. (1984). Women, alcohol and sexuality. *Advances in Alcohol and Substance Abuse*, 4(1), 41-56.
- Covington, S., & Surrey, J. (1997). The relational model of women's psychological development: Implications for substance abuse. In S. Wilsnack & R. Wilsnack (Eds.), *Gender and alcohol: Individual and social perspectives* (pp. 335-351). New Brunswick, NJ: Rutgers University Press.
- Finkelstein, N. (1993, July). The relational model. In D. Kronstadt, P.F. Green, & C. Marcus (Eds.), *Pregnancy and exposure to alcohol and other drug use* (pp. 126-163). Washington, DC: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention.
- Finkelstein, N., Kennedy, C., Thomas, K., & Kearns, M. (1997, March). *Gender-specific substance abuse treatment*. Washington, DC: Center for Substance Abuse Prevention, draft.
- Galbraith, S. (1994). *Best practices: Models of care for pregnant alcoholic and drug dependent women and their children*. New York: Legal Action Center.
- Herman, J. (1992). *Trauma and recovery*. New York: HarperCollins.
- Jellinek, E. (1946, June). Phases in the drinking history of alcoholics: Analysis of a survey conducted by the official organ of Alcoholics Anonymous. *Quarterly Journal of Studies on Alcohol*, pp. 1-10.
- Miller, J.B. (1976). *Toward a new psychology of women*. Boston: Beacon Press.
- Miller, J. (1986). *What do we mean by relationships?* (Work in Progress No. 22). Wellesley,

- MA: Stone Center.
- Miller, J.B. (1990). *Connections, disconnections, and violations*. (Work in Progress No. 33). Wellesley, MA: Stone Center.
- Northrup, C. (1994). *Women's bodies, women's wisdom*. New York: Bantam.
- Parks, G. (1997). *What works in relapse prevention?* Paper presented at ICCA Fifth Annual Research Conference, Cleveland, OH.
- Sandmaier, M. (1992). *The invisible alcoholics: Women and alcohol* (2nd ed.). Blue Ridge Summit, PA: TAB.