

Helping Women Recover: Creating Gender-Responsive Treatment

By

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in

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In the last two decades, clinicians and researchers have developed a solid body of knowledge in best practices for the treatment of addicted women. Research indicates that clinical services for addiction treatment that address women's specific issues are more effective for women than are traditional programs, originally designed for men (Abbott & Kerr, 1995; Carten, 1996; Center for Substance Abuse Treatment, 1994; Covington, 1998a; Finklestein, 1993). However, many of the services that women encounter in the public and private sectors are not designed for women. In addition, they often lack cohesion and consistency because they are constructed from a variety of resources that are not consistent in their theoretical bases.

This chapter presents a new, integrated approach to women's treatment, based on theory, research, and clinical experience. The treatment philosophy and guiding principles discussed are designed to create a foundation for clinical thought and practice. These principles can be applied in any setting (inpatient, outpatient, private practice, therapeutic community, criminal justice, and so on) and to any modality (individual, group, or family therapy). A key concept is that if we are to develop effective treatment for women, we must include the experience and impact of living as a woman in a male-based society--in other words, gender--as a part of the clinical perspective. The definition of the term *gender-responsive* used in this chapter is as follows: *creating an environment through site selection, staff selection, program development, content, and material that reflects an understanding of the realities of women's lives, and is responsive to the issues of the clients* (Covington, 2001). Therefore, this chapter focuses on both the content and context of women's treatment.

UNDERLYING THEORY AND RESEARCH

A basic principle of clinical work is to know who the client is and what she brings into the treatment setting. Until recently, this in-depth knowledge about the woman addict was missing. However, recent research provides important information for understanding the development of addiction in women and the critical issues that must be considered in the design and process of treatment.

Research demonstrates that addiction is rarely, if ever, a single-dimension issue for women. Addiction is always a part of a larger portrait that includes a woman's individual

history, and the social, economic, and cultural factors that create the context of her life. Therefore, in thinking about treatment for addicted women, it is essential to start from the premise that theory and practice should be based on a multi-dimensional perspective. As Abbott & Kerr (1995) suggest, "If treatment is to be effective, it must...take the context of women's lives into account" (p. 3).

In examining the life histories of addicted women, we can see two elements that many women share in addition to their dependence on chemicals: the lack of healthy relationships and the experience of trauma (for example physical abuse, sexual abuse, poverty, racism) (Covington, 1999). These elements create multiple issues that are interrelated in women's lives and need to be considered when assisting a woman into recovery. Therefore, we will discuss three theoretical formulations that will provide a framework of thought (the foundation) for clinical services: theory of addiction, theory of women's psychological development, and theory of trauma.

Theory of Addiction

It is important to have a theoretical model to work from when treating addicted women.

Disorder versus Disease

Historically, addiction was viewed as a sign of lapsed morals. In the 1950s, mental health professionals began to view addiction as a sign of an underlying psychological disorder. The belief was that if one could resolve the underlying disorder, the addiction would disappear. As the chemical dependency field was born, its practitioners viewed addiction not as a symptom but as a primary condition with its own symptoms. The condition could not be managed through will power; instead, the afflicted person needed to make lifestyle changes to achieve emotional and physical stability, just as in the case of a disease such as diabetes. The concept of addiction as a disease gained wide acceptance. However, the analogy to diabetes still saw the disease rooted in the physical aspects of the individual. As health professionals in many disciplines began revising their concepts of all disease, a more holistic view of health came to acknowledge not only the physical aspects of disease but also the emotional, psychological, and spiritual aspects (Northrup, 1994). Alcoholics Anonymous (AA) was one of the first proponents of a holistic health model of the disease of addiction, encompassing the physical, emotional, psychological and spiritual aspects.

In addition to this broader view, we have learned to also consider the environmental and sociopolitical aspects of addiction and other diseases. Cancer can be used as an analogy. Like addiction, cancer has physical, emotional, psychological, spiritual, and environmental dimensions. B. Siegel (personal communication, Oct. 1996) reports that 80 percent of doctors link cancer to lifestyle choices (diet and exercise) and the environment (pesticides, emissions, nuclear waste, and so on). Cancer also has sociopolitical aspects, especially when one considers the huge profits made by the producers of carcinogenic products. Even though cancer and addiction share a number of characteristics, cancer is universally acknowledged as a disease; addiction is not. Moreover, addiction is often

treated as a crime. This has resulted in a huge population increase in our prisons, where few inmates receive adequate treatment.

Although the debate over models will probably continue, the disease perspective offers a more helpful approach to the treatment of addiction because it is more comprehensive and thus meets the requirements for a multidimensional framework. The disorder model focuses on social learning theory and a cognitive-behavioral approach (Parks, 1997), thereby minimizing the importance of genetic studies, the affective aspects of the problem and its solution (Brown, 1985), and its sociocultural and environmental elements. The holistic health model allows clinicians to treat addiction as the primary problem while also addressing the complexity of issues that women bring to treatment: genetic predisposition, health consequences, shame, isolation, a history of abuse, or a combination of these. For example, though some women may have a genetic predisposition to addiction, it is important in treatment to acknowledge that many of them have grown up in environments in which drug dealing and addiction are ways of life. When addiction has been a core part of the multiple aspects of a woman's life, the treatment process requires a holistic multidimensional approach.

Research Studies on Males versus Females

Because the research on male addicts has focused on different topics from those conducted on female addicts, research has yielded different types of data and suffered from information gaps. For example, many studies have examined alcoholism in fathers and sons, clearly indicating a genetic link in men. Few studies, however, have focused on the genetic link in women.

Environmental and psychosocial factors in women's addictions have been studied more thoroughly, however (Finkelstein, Kennedy, Thomas, & Kearns, 1997). *Stigma* (severe social disapproval) is the main psychosocial issue differentiating the substance abuse of females from that of males. Although drinking alcohol is often seen as "macho" in men, it conflicts with society's view of femininity and the roles of wife and mother. The words still associated with female addicts are *slut*, *lush*, and *bad mother*. Women often internalize this stigma and feel guilt, shame, despair, and fear when they are addicted to alcohol or other drugs. Mothers also know that addiction may cause them to lose their children. Stigma and the threat of severe consequences often lead women and their families to minimize the impact of substance abuse by using denial.

The Spiral of Addiction and Recovery

In addition to seeing addiction holistically, we can envision the process of addiction and recovery as a spiral (Brown, 1985; Covington, 1999), as illustrated in figure 3.1. The downward spiral of addiction revolves around the drug of choice. Addiction pulls the addict into ever-tightening circles, constricting her life until she is completely focused on the drug. The object of her addiction becomes the organizing principle of her life. Using alcohol or other drugs, protecting her supply, hiding her addiction from others, and cultivating her love-hate relationship with her drug begin to dominate her world.

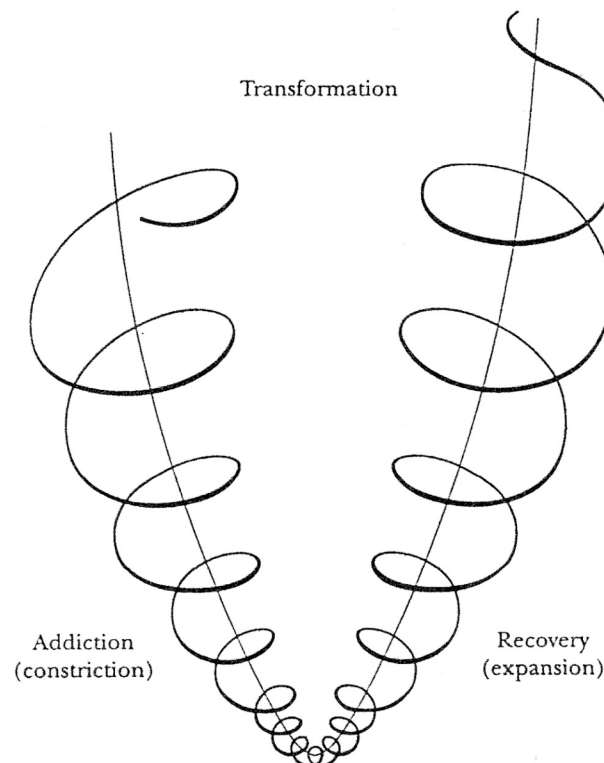
When a woman is in this downward phase of constriction, the therapist's task is to break through her denial. The woman must come to a point of transition, in which she shifts her perceptions in two ways. She must shift from believing "I am in control" to admitting, "I am not in control." She must stop believing "I am not an addict" and admit, "I am an addict" (Brown, 1985, p. 34).

Both shifts can feel humiliating. Our society's double standard inflicts far more shame on a woman who has an addiction than on a man who does.. Although society may stigmatize a male addict as a "bum", it rarely attacks his sexuality or his competence as a parent. We must understand that a woman who enters treatment may come with a heavy burden of shame. She does not need to be shamed further; rather, she needs to be offered the hope that she can heal.

The upward spiral of recovery revolves around the drug in ever-widening circles, as the addiction loosens its grip and the woman's world expands away from the drug. Her world grows to include healthy relationships, an expanded self-concept, and a richer sexual and spiritual life.

Notice that the process is not merely one of turning around and ascending the same spiral but one of profound change, so that the woman ascends a different spiral. When women speak of recovery, they speak of a fundamental transformation: "I'm not the same person. I'm different than I was."

FIGURE 3.1. THE SPIRAL OF ADDICTION AND RECOVERY.



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Addiction as a Neglect of Self

The generic definition of the word *addiction* used in this chapter is *a chronic neglect of self in favor of something or someone else*. This neglect of self includes patterns of repetition and compulsion that reinforce self-destructive behavior, cognition, and affect.

Many practitioners who have studied men often see addicts as self-focused and perceive their task as breaking that obsession with self. Men who are addicted typically build up grandiose false selves that must be challenged before they can discover and cultivate their true selves. The descriptive terms used in AA include *king baby*, *inflated self ego* and *grandiosity* (Alcoholics Anonymous, 1976). The confrontation used in traditional therapeutic communities and early treatment programs was designed to break through this false, grandiose self of men. Addicted women, however, generally have a diminished sense of self. They have learned to negate and neglect their true selves in favor of other people and their drug(s) of choice. Female addicts may appear self-obsessed because their lives are constricted around their drugs, while healthy give-and-take with others recedes into the background. However, their obsession with their drugs hides their true selves.

Questions then arise: How does a woman shift from a chronic neglect of self to a healthy care of self? How does a woman shift from constriction to expansion and growth? How does a woman grow and recover? These questions alert clinicians to the importance of understanding women's psychological development.

Theory of Women's Psychological Development

The spiral shown in Figure 3.1 shows recovery as an upward spiral of growth and expansion. In order to assist women in the transition from addiction to recovery, it is important to understand how women grow and develop.

Growth-Fostering Relationships

Traditional theories of psychology have described human development as a progression from childlike dependence to mature independence through a process of separation and individuation. Only when the individual was self-sufficient and autonomous was that person perceived to be capable of adult intimacy.

In her groundbreaking book *Toward a New Psychology of Women*, Miller (1976) challenged the assumption that separation is the route to intimacy. She said that connection, not separation, is the guiding principle of growth for women. Her work led to the creation of the Stone Center at Wellesley College, established to explore the qualities of relationships that foster healthy growth in women. According to the relational model, the primary motivation for women throughout life is to establish a strong sense of connection. Women develop a sense of self and self-worth when their actions arise from and lead back to connections with others. Healthy, growth-fostering relationships create increased vitality, empowerment, self-knowledge, and self-worth, and a desire for more

connection. Such relationships are mutual, empathic, creative, and empowering for all participants.

Mutuality means that each person in a relationship can reveal his or her feelings and perceptions and can be moved by the feelings and perceptions of the other. Each person and the relationship itself can change and move forward because there is mutual influence and responsiveness. *Empathy* is a highly developed ability to join with another at a cognitive and affective level without losing connection with one's own experience (Covington & Surrey, 1997; 2000). An empathic person feels 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, they feel more able to share power for constructive, creative ends.

Healthy connections are crucial for women; their psychological problems can be traced to disconnection or violations within relationships--in families, with personal acquaintances, or in society at large (Miller, 1986). When a woman is disconnected from others or involved in abusive relationships, she experiences disempowerment, confusion, and diminished vitality and self-worth--fertile ground for addiction.

When clinicians are trying to help women to change, grow, and heal from addictions, it is critical that they place women in environments in which they can experience mutual, empathic, healthy relationships with their counselors and with one another.

Addiction and Relationships

From the perspective of the relational model, women often use drugs in order to make or keep connections. Finkelstein (1993) states that clinicians need to consider past and current family relationships, relationships with friends and partners, and relationships developed within the treatment context.

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 alcohol or other drugs. 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 men to provide emotional support (and financial support for any children). Their disappointment often leads to solace in drug use. Fourth, many addicted women report physical abuse from men. Drugs help numb the pain of abusive relationships that also lack mutuality and empathy. Fifth, studies indicate 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 fit into their relationships. For example, a sexually dysfunctional woman may use alcohol to become willing to engage in sex. In addition, nonmutual or abusive relationships produce what Miller (1990) calls a "depressive spiral": diminished 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--for example, "Alcohol was my true love," or "Food was my source of comfort." However, as the addiction progresses, a woman finds that this friend becomes lethal: "I turned to Valium, but Valium turned on me" (Covington & Surrey, 1997; 2000). Addiction is a relationship that constricts a woman's life. The task in helping a woman to recover is to help her transfer her attachments to addictive "relationships" (with substances, people, or both) to sources of growth-fostering connections, such as her therapist, her mutual-help group, or members of her recovery group.

Theory of Trauma

A history of abuse drastically increases the likelihood that a woman will abuse alcohol and other drugs. In a comparison study of women who were addicts and women who were not (Covington & Kohen, 1984), 74 percent of the addicted women reported sexual abuse, 52 percent reported physical abuse, and 72 percent reported emotional abuse. In contrast, 50 percent of the women who were not addicts reported sexual abuse, 34 percent reported physical abuse, and 44 percent reported emotional abuse. "Moreover, the addicted women were found to have been abused sexually, physically, and emotionally by more perpetrators, more frequently and for longer periods of time than their non-addicted counterparts. The addicted women also reported more incidents of incest and rape" (Covington & Surrey, 1997, p. 342).

The connection between addiction and interpersonal violence is complex and multifaceted; for example, substance abusing men are often violent toward women and children; substance abusing women are particularly vulnerable targets for violence; and childhood and current abuse increase a woman's risk of substance abuse (Miller, 1991). There are also gender differences in terms of abuse. "While both male and female children are at risk for abuse, females continue to be at risk for interpersonal violence in their adolescence and adult lives. The risk for males to be abused in their teenage and adult relationships is far less than for females" (Covington & Surrey, 1997, p. 341).

Consequently, the treatment of substance abusing women must take into account the likelihood that most clients will have suffered abuse (Covington, 1998a, 1998b). "Moreover, trauma is not limited to suffering violence; it includes witnessing violence as well as stigmatization because of gender, race, poverty, incarceration, or sexual orientation. Trauma also increases the likelihood of interaction with the criminal justice system" (Covington, 1998b). Thus, in treating the addiction, clinicians need to understand that they also are probably treating a trauma survivor. Many women who used to be considered "treatment failures" because they relapsed may now be understood as trauma survivors who returned to alcohol or other drugs in order to medicate the pain of trauma. Our increased understanding of trauma offers new treatment possibilities for substance abusing trauma survivors (Barrett & Trepper, 1991). By integrating trauma treatment with addiction treatment, there is less risk of trauma-based relapse.

Traditional addiction treatment often does not deal with abuse issues in early recovery, even though they are primary triggers for relapse among women (Covington & Surrey, 1997; 2000). Although clinicians do not need to be experts in trauma recovery, it is important to have an understanding of trauma theory and a conceptual framework for clinical practice. In *Trauma and Recovery*, Judith Herman (1992) offers a framework that considers trauma a disease of disconnection and presents a three-stage model for trauma recovery: safety, remembrance and mourning, and reconnection. It is important to maintain support for addiction recovery throughout the three stages of trauma treatment.

Stage 1, safety, focuses on caring for oneself in the present. On entering addiction treatment, a woman typically is in Stage 1 and her primary need is safety. “Survivors feel unsafe in their bodies. They also feel unsafe in relation to other people” (Herman, 1992, p. 160). 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. Clinicians also can teach women to feel safe *internally* by teaching them to use self-soothing techniques, rather than drugs, to alleviate depression and anxiety.

Herman emphasizes that a trauma survivor who is working on safety issues needs to be in a homogenous recovery group (including the facilitator). Until they are in Stage 3, women may not want to talk about physical or sexual abuse in groups that include men.

Herman cites twelve step groups as the type appropriate for Stage 1 recovery because of their focus on present-tense issues of self-care in a supportive, structured environment. This stage focuses on issues that are congruent with the issues of beginning recovery.

Stage 2, remembrance and mourning, focuses on the trauma that occurred in the past. For example, in a survivors' group, participants tell their stories of trauma and mourn their old selves, which the trauma destroyed. Typically, a woman who is stabilized in her addiction treatment may be ready to begin Stage 2 trauma work. Although the risk of relapse can be high during this phase of work, this risk can be minimized through anticipation, planning, and the development of self-soothing mechanisms.

Stage 3, reconnection, focuses on developing a new self and creating a new future. Stage 3 groups are traditionally unstructured and heterogeneous (as in a psychodynamically-focused psychotherapy group). This phase of trauma recovery corresponds to the ongoing recovery phase of addiction treatment. For some women, this work can only occur after several years of recovery.

* * *

We have looked at three theoretical perspectives: addiction, women's psychological development, and theory of trauma. Women often have been expected to seek help for addiction, psychological disorders, and trauma from separate sources and to put together for themselves what they learned from a recovery group, and from a clinician. This

expectation that women do the integration for themselves places an unnecessary additional burden on recovering women (Brown, Huba, & Melchior, 1995). It is important that clinicians use a comprehensive, gender-responsive model that integrates all three theoretical approaches so as to remove that burden from women and increase their potential for recovery and healing.

GUIDING PRINCIPLES OF WOMEN'S TREATMENT

In addition to a comprehensive theoretical framework for women's treatment, there are six key principles to consider in creating the therapeutic process and milieu. These core principles are based on the theories already presented (the theory of addiction, theory of women's psychological development, and theory of trauma) and on clinical experience.

1. *Develop and use women's groups.* Research (Aries, 1976; Bernandez, 1978, 1983; Graham and Linehan, 1987) indicates that group dynamics differ between all-female groups and mixed female-male groups. Fedele and Harrington (1990) conclude that single- and mixed-sex groups are appropriate for women at different stages of their lives and at different stages of their recovery: Women-only groups are the modality of choice for women in the early stage of addiction recovery and for sexual abuse survivors. When a woman needs to share and integrate her experiences, ideas, and feelings to create a sense of self (as in early recovery), a single-sex group is preferable. When the woman's experience has been validated, she has more empathy for herself and is more empowered (as in later recovery), a mixed group may take her to the next stage of development. So although mixed groups may have their place in later recovery, it is important that treatment for early addiction recovery use all-female groups (with a female facilitator).

2. *Recognize the multiple issues involved, and establish a comprehensive, integrated, and collaborative system of care.* The Center for Substance Abuse Treatment (1994), a federal agency, identifies seventeen critical areas of focus for women's treatment. These issues underscore the complexity of women's treatment, the need for a comprehensive perspective, and the importance of theoretical integration and collaboration in clinical practice.

1. The causes of addiction, especially gender-specific issues related to addiction (for example, factors related to onset of addiction and social, physiological, and psychological consequences of addiction)
2. Low self-esteem
3. Race, ethnicity, and cultural issues
4. Gender discrimination and harassment
5. Disability-related issues
6. Relationships with family members 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 children, family members, partners, and alcohol and other drugs
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. Development of life-plans
17. Child care and child custody

The list takes into account the physical, psychological, emotional, spiritual, and sociopolitical aspects of the holistic health model of addiction. It also reflects the need for a collaborative approach. These seventeen issues may also be grouped into four major areas: self, relationships, sexuality, and 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).

3. *Create an environment that fosters safety, respect, and dignity.* The treatment setting has a profound effect on a woman's recovery. Both relational theory and trauma theory take this impact into account, emphasizing the context of treatment and providing guidelines for developing a therapeutic environment and culture. Women recover in an environment that facilitates healing--one that is characterized by the elements of safety, mutuality, and empowerment discussed in the section on relational theory. *Safety* means that there are appropriate boundaries between the client and the clinician (that is, the environment is free of physical, emotional, and sexual harassment). Although it may be possible for a clinician to guarantee absolute safety only in a private practice setting, participants in treatment programs need to know that the environment is likely to be safe for them.

In this context, *mutuality* means that exchanges between the treatment provider and the client are mutual rather than authoritarian. Women sense when a therapist 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 woman are alike. As this kind of mutual, empathic, compassionate, and respectful connection is modeled in group settings, 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 women to believe in and exercise their abilities, and in group settings she enables them to practice and observe one another using power appropriately. Empowerment also encourages women to find their inner sources of power.

4. *Develop and use a variety of therapeutic approaches.* To fully address the needs of addicted women, it is important to work on multiple levels, using behavioral, cognitive, affective-dynamic, and systems perspectives. At this time, cognitive-behavioral therapy is often touted as the best treatment approach, although research does not support the

assumption of cognitive-behavioral programming models as the sole basis of treatment for females. Attention to affect and, often, to early childhood experiences of trauma is frequently missing in women's treatment.

Cognitive-behavioral theory assumes that affect (the feeling function) can be addressed through cognitive process (thinking). This therapeutic approach is too narrowly focused for women at any stage, but especially at the points of active addiction and of movement into abstinence and early recovery. Women's treatment needs to be based on the premise of the whole person, incorporating the holistic model of addiction and emphasizing affective, cognitive, and behavioral change. The affective aspect is especially important for females because their substance-abusing behavior needs to be understood in the context of their emotional lives.

Miller and Stiver (1997, p. 212) offer the following analysis of the current emphasis on cognitive functioning: "This separation of thought and feeling seems clearly linked to a long-standing gender division in Western culture. Thinking has been linked with men and is the valued capacity; feeling has been linked with women and is disparaged. In contrast, we believe that all thoughts are accompanied by emotions and all emotions have thought content. Attempting to focus on one to the neglect of the other diminishes people's ability to understand and act on their experiences."

For many women, the absence of feeling or reduced feeling is common in early recovery (Brown, 1985). For others, it is just the opposite; the beginning of abstinence may open up a flood of painful affect and memory. Either way--no feeling, or overwhelming emotion--women need to learn how to express their feelings appropriately and to contain them in healthy ways. Females frequently become dependent on drugs in order to seek relief from painful emotions. In recovery they must come to terms with the feelings and the drive to cope with them in self-destructive ways. Recovery involves a shift from acting out destructive behaviors in order to displace feeling or rid oneself of feeling, to accepting and integrating feeling, a process that involves learning to calm oneself through self-soothing techniques and sharing with others.

Women may experience this opening up process as a bind. Because females are often raised to suppress their feelings and to be compliant, a treatment program that is unable or unwilling to work with women's emotions can feel like the abusive environment in which they learned to keep silent and turn to alcohol or other drugs and addictive behaviors. Such silence encourages them to avoid dealing with issues that can lead to relapse (Pepi, 1998). As feelings emerge in early recovery, women may feel confused unless they have a context that encourages awareness and expression of feeling in contained and healthy ways.

5. *Focus on women's competence and strength.* In a traditional treatment model, the therapist typically approaches assessment with a problem focus: What is missing in the client? or What is wrong with the client? Many women already are struggling with a poor sense of self because of the stigma attached to their addictions, their parenting histories,

their trauma, or their prison records, for example. It is difficult and often anti-therapeutic to add another problem to the woman's list of perceived failures.

A strength-based (asset) model of treatment shifts the focus from targeting problems to identifying the multiple issues a woman must contend with and the strategies she has adopted to cope. This has been referred to as assessing a woman's "level of burden" (Brown et al., 1995). The focus is on support, rather than on confrontation to break her defenses (Fedele & Miller, 1988).

In using an asset model, the therapist helps the client see the strengths and skills she already has that will aid her healing. The clinician looks for the seeds of health and strength, even in the woman's symptoms. For example, the clinician portrays a woman's relational difficulties as efforts to connect, rather than as failures to separate or disconnect. The counselor repeatedly affirms the woman's abilities to care, empathize, use her 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, Kennedy, Thomas & Kearns, 1997, p. 6).

6. Individualize treatment plans, and match treatment to identified strengths and issues. Just as women's lives are different from men's, women's lives are not all the same. Although there are common threads because of gender, it is important to be sensitive to differences and to acknowledge both similarities and differences. For example, there are differences in the lives of African-American women, Hispanic women, and Asian women. There are differences between heterosexual women, bisexual women, and lesbian women. There are differences between older women and younger women. There are differences resulting from privilege and oppression.

It has become evident that treatment needs to be individualized in order to be effective. The Project on Women, Addiction, and Recovery (P.O.W.A.R.) chart, shown in figure 3.2, is an assessment tool that was developed in one of the author's research projects on women and addiction (Covington, 1990). It illustrates one way to individualize treatment for women by integrating women's treatment issues with a developmental model of recovery. On the left side of the chart are some of the major issues that can impact women's recovery. These are some of the major areas of focus in treatment. Across the top of the chart, a timeline represents the stages in a developmental model of recovery. For each individual woman, there are issues in the foreground of her life and issues in the background at any particular time. Depending on where she is in recovery, an issue may shift from background to foreground and vice versa. In each recovery stage, the issues that are in the foreground need to be addressed most directly at that time.

FIGURE 3.2. MODEL FOR INDIVIDUALIZED TREATMENT.

	Stages			
	Active Addiction	Transition	Early Recovery	Ongoing Recovery
Aspects of Addiction				
• Physical				
• Behavioral				
• Cognitive				
• Affective				
• Other addictions				
Self				
• Sense of self (self-image)				
• Self-care				
• Race, ethnicity, cultural issues				
• Disability-related issues				
Relationships				
• Attachment issues				
• Interpersonal violence				
• Parenting, child care, custody				
• Support system				
Sexuality				
• Sexual dysfunctions				
• Body image				
• Sexual identity				
• Sexual abuse				
Spirituality				
• Creating connection				
• Grief work				
• Prayer, meditation				
• Vision (development of life plan)				

Source: Unpublished research by Stephanie S. Covington, 1990.

As a woman moves out of the limitations and constrictions of addiction toward discovery and growth (see Figure 3.1), she may find that certain themes recur. As she deals with them, she confronts them at increasingly higher levels of self-awareness and strength. When women speak of recovery, they speak of a fundamental transformation: "I'm not the same person." It is important to see recovery as a life-long process of increased consciousness and growth, with shifts in focus and issues. This is true for recovery from both addiction and trauma.

A MODEL TREATMENT PROGRAM FOR WOMEN

Helping Women Recover (Covington, 1999) is a program curriculum for creating gender-responsive addiction treatment based on the theories and principles outlined in this chapter. The *Facilitator's Guide* for the program is a step-by-step manual containing the theory, structure, and content for running groups. *A Woman's Journal*, the participant's workbook, allows women to process and record the therapeutic experience. The materials can be used in a variety of settings, and the exercises can be adapted for work with individuals. The program is organized into four modules: self, relationships, sexuality, and spirituality. These reflect the four areas that women say are the triggers for

relapse and the areas of greatest change in recovery (Covington, 1994). The modules incorporate the seventeen issues outlined by the Center for Substance Abuse Treatment (listed earlier). The following paragraphs briefly describe the specific topics covered within each module:

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

2. *Relationship module*: Women explore their roles in their families of origin (Covington & Beckett, 1988); discuss myths about motherhood and their relationships with their mothers; review their relationship histories, including any interpersonal violence; and consider how they can build healthy support systems. To assist the participants' growth, the counselors in group settings model healthy relationships among themselves and with the participants.

3. *Sexuality 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 often is neglected in addiction treatment, although it is a major cause of relapse (Covington, 1997; 2000). Healthy sexuality is essential to a woman's sense of self-worth. Women may enter recovery with arrested sexual development, because substance abuse often interrupts the process of healthy sexual development. Many also struggle with sexual dysfunction, shame, fear, and trauma that must be addressed so that they do not return to addiction to manage the pain of these difficulties.

4. *Spirituality module*: Women are introduced to the concepts of spirituality, prayer, and meditation. Spirituality deals with transformation, connection, meaning, and wholeness--important elements in recovery. Connecting to her own definition of spirituality is essential to a woman's recovery, so each is given an opportunity to experience aspects of spirituality and to create a vision for her future in recovery.

MUTUAL-HELP GROUPS FOR WOMEN

For centuries women have sought to teach and support themselves and each other by meeting in groups and sharing information and experiences. In traditional and modern societies alike, women continue to meet to wash clothes and sew quilts together, share stories around a coffee pot, meet for lunch during a busy workday, play cards and watch children. These activities have always and will always involve offers of solace and support that come in casual conversation with dependable and cherished women friends.

Today, women who meet in mutual-help groups do so for many of the same reasons that their forbearers gathered together. Few developments of recent years have become so widespread as the use of mutual-help groups to aid people in recovering from alcohol

and other drug addiction. The phenomenon is most obviously measured by the growth in the sheer numbers of such groups. These include AA, Al-Aanon, and Narcotics Anonymous, which are the predominant examples of mutual help groups concerned with addiction. Moreover, the so-called twelve step model which originated in AA, is now used by over 126 “anonymous” groups to deal with a host of other problems (Alcoholics Anonymous, 1993). People use them to cope with a spectrum of substances, behaviors, and processes. Overeating, gambling, workaholism, sexual and incest issues, and other relationship topics are now addressed in mutual-help groups modeled after AA. Quite clearly these are people with problems to which complete solutions have not been found in traditional approaches offered by established helping professionals (Fiorentine, 1999).

A major advantage of mutual-help groups for women is that they are free and, in most urban communities, readily available throughout most parts of the day. It is in this respect that they are most unlike conventional problem-solving techniques, whereby help is provided only on occasion, almost exclusively as a response to a specific request from a particular individual.

In recent years, twelve-step programs have been critiqued in various ways and, as some feminists have pointed out, the language used is simplistic, sexist and reductionist (Berenson, 1991; Rapping, 1996). Feminists are particularly concerned about the twelve steps’ emphasis upon powerlessness as liberating. In contrasting the recovery movement with the women’s movement, Marianne Walters (1990) points out that “one movement encourages individuals to surrender to a spiritual higher power, where the other encourages people to join together to challenge and restructure power arrangements in the larger society” (p. 55). What is often missed in feminist analysis is that masculine power *over* is what is being relinquished in order to experience the feminine power *with*, power *to be able* -- in other words, a sense of empowerment (Miller, 1982). “The process of recovery from addiction is a process of recovering a different, more feminine, sense of power and will” (Berenson, 1991, p. 74). There is also a confusion between surrender and submission. “When we submit, we give in to a force that’s trying to control us. When we surrender, we let go of our need to control” (Covington, 1994, p.48). Recovery encourages surrender and giving up the illusion of control. Feminist writer Marilyn French (1985) states that “life is the highest value for ‘feminine’ people; whereas control is the highest value for ‘masculine’ people” (p. 93).

If we look at the underpinnings of Alcoholics Anonymous we can see that it was actually very radical for the 1930s, the time it was founded, and that this continues to be true even today. Twelve-step programs are free, a radical concept in a capitalistic society; they are nonhierarchical, a radical idea in a patriarchal society; and they are spiritual, a radical stance in a nonspiritual society. As previously stated, women grow and develop in relationship, and twelve-step programs can provide a growth-fostering relational context and can offer their members social support through the creation of a caring community (Covington, 1991; Covington & Surrey, 1997, 2000). These programs can also create a safe environment, which is an essential element for recovery from trauma (Herman, 1992). Although some critics have focused on the sexist language in

which the twelve steps are couched, many women are able to interpret the steps in ways that are distinctly personal, meaningful, and useful to themselves (Covington, 1994).

CONCLUSION

The reasons that the majority of addiction treatment is still based on the male experience are complex. Some of the reasons are related to stereotypic views of women and men. Others relate to a lack of acknowledging gender differences as well as gender-based needs. It is important to understand and acknowledge some of the dynamics inherent in a gendered society; for example, when something is declared gender-neutral or genderless, it is essentially male (Kaschak, 1992). In addition, researchers, theorists, and policymakers are still predominantly men, as are the majority of those who direct addiction treatment programs. In most cases, this means they view and experience the world through a different lens that often excludes women's reality. Therefore, the primary barriers to providing gender-responsive treatment are multilayered: they are theoretical, administrative, and structural, and involve policy and funding decisions.

This chapter has presented an integrated theoretical philosophy with guiding principles, which focuses on both the content and the context of women's treatment in hopes of being a resource to those who seek to eliminate these barriers. Just as it is essential to look at each woman's addiction from a multidimensional perspective and acknowledge the interconnectedness of her life issues, it is essential that the systemic barriers to gender-responsive services for women be seen from a multidimensional and interconnected perspective.

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