Evaluating, Treating and Monitoring the Female DUI Offender

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The number of females arrested and re-arrested for driving under the influence of alcohol or other drugs has increased in the past two decades. Increased female representation within those arrested for driving under the influence (DUI) of alcohol or other drugs suggests the need for more nuanced approaches to their evaluation, treatment, sentencing and supervision. The purpose of this short monograph is to briefly review what is known about: 1) the prevalence of female drinking and driving, 2) the profile of the female DUI offender, 3) gender-specific patterns of alcohol and drug dependency, 4) special approaches to the treatment of the female DUI offender, and 5) patterns of long-term recovery for women. The monograph includes recommendations drawn from the scientific literature and the authors' experience treating addicted women and evaluating gender-specific treatment programs.

Women and the State of Alcohol and Drug Studies

The number and quality of studies of alcohol- and drug-related problems, addiction and recovery among American women have significantly increased over the past two decades. In our review of the scientific literature on substance-impaired driving among women, we found that that majority of these studies had been published since 1990 and that the methodological rigor of these studies had significantly increased since 2000. A just-published review (Greenfield, et al., 2007) that examined addiction treatment outcomes for women found that 90% of all of the research on gender differences in treatment outcomes had been published since 1990—40% since 2000. These studies are generating findings with significant implications for the design of intervention programs for females arrested for driving under the influence (DUI). For years, female patterns of DUI were obscured in the much larger sea of male offenders. Science has begun to open a window on this previously invisible population of women and point the direction to more effective approaches to evaluation, treatment, sentencing and supervision.

Consumption Patterns

The best source of data available on adult patterns of alcohol, tobacco and other drug use is the regular National Survey on Drug Use & Health conducted by the Substance Abuse and Mental Health Service Administration. The most recent of these surveys (2003) revealed that 74.5 million (61%) females aged 12 or older and 30.0 million (70%) males aged 12 or older consumed alcohol during the past year. This same survey revealed that 15.2 million (12%) females and 19.8 million (17%) males had used an illicit drug during the past year. Data on alcohol and other drug consumption patterns of younger females is available through the annual Monitoring the Future Survey sponsored by the National Institute on Drug Abuse. 52.3% of female twelfth graders report consumption of alcohol in the past 30 days and 24.4% of females (versus 33% for males) report having consumed 5 or more drinks in a row in the past two weeks.

In 1975, the spread between males and females on this last figure was 23 percentage points, reflecting the subsequent leveling of differences in alcohol consumption patterns between women and men. Similar trends are occurring for illicit drug use with 30.1% of female high school seniors (compared to 34.3% of male high school seniors) report having consumed an illicit drug in the past twelve months (Johnston, 2006). Older women are more likely than younger women to consume only alcohol or to consume alcohol and prescription drugs. Younger women are more likely to combine alcohol and illicit drugs (Lex, 1994).

Changes in psychoactive drug consumption by women, particularly young women, have been linked to broader changes in gender roles and to promotional targeting of women by the alcohol, tobacco and pharmaceutical industries special products and appeals linking these products to beauty, wealth, social popularity, sophistication, sexuality and, perhaps most offensively, with liberation ("You've come a long way, Baby!") (White & Kilbourne, 2006). Increases in DUI arrests for women reflect both changes in social norms about women and alcohol, but also the fact that more women are driving and driving more frequently and more miles (Popkin, 1991). It is interesting to note that increased substance use among women and increased driving does not convert into risky driving decisions to the degree seen in men. The greater risk for men for DUI and DUI recidivism may well be linking to their increased propensity for impulsivity, risk-taking and aggression than differences in substance consumption (Elliott, Shope, Raghunathan & Waller, 2006). Females seem to drive more cautiously with or without alcohol in their systems (Zador, Krawchuk, & Voas, 2000).

DUI Prevalence Rates among Women

In the National Survey on Drug Use and Health, 11.4% of women aged 21 or over (compared to 22% of men aged 21 or over) reported driving under the influence of alcohol or other drugs in the past year (NSDUH Report, July 1, 2005). However, “as consumption increases, the male-female difference decreases and, in the heaviest drinking group, the rate of driving while intoxicated is almost as high among women as it is for men” (Johnson, Gruenwald & Treno, 1998). While the total volume of female DUI arrest rates is far lower than those for men, DUI arrests constitute the largest category of alcohol-related crimes that bring women into contact with the criminal justice system (Parks, Nochajski, Wieczorek & Millerm 1996). As such, these arrests events constitute a significant opportunity to intervene with women who are experiencing significant alcohol problems. Yet, in Illinois, so few women are referred to women specific treatment.

Looking at the specific issue of drug-impaired driving, 3% of females age 12 or older (compared to 6% of males) report driving under the influence of a drug (NSDUH Report, September 16, 2003).

The gender discrepancy in these rates is further indicated in fatal crash data revealing that male drivers involved in fatal motor vehicle crashes are almost twice as likely as female drivers to be intoxicated with a blood alcohol concentration (BAC) of 0.08% or greater (NHTSA 2004b), however the percentage of male drivers in alcohol-related fatal crashes has decreased while female drivers in such crashes have increased (Waller & Blow, 1995; Abdel-Aty & Abdelwahab, 2000). Several studies have also concluded that females are at greater risk of involvement in fatal crashes at lower levels of intoxication than are males (Waller & Blow, 1995).

In Illinois, 17% of those arrested for DUI are women (DUI Fact Book, 2004), but DUI

arrest for women have risen both nationally and in Illinois in recent decades (Parks, Nochasjski, Wieczorek & Millerm 1996).

Studies of the DUI recidivist report that female DUI offenders are less likely to be re-arrested than are male DUI offenders. In a follow-up study of 3,425 DUI offenders, Wells-Parker and colleagues (1991) found males twice as likely to recidivate as females. Most studies of DUI recidivists conclude that 90-95% of recidivists are male (White & Gasperin, in press).

Profile of Female DUI Offenders

Only a small number of studies have focused specifically on the profile of the female DUI offender, and even fewer that profile the female DUI recidivist. Major findings from existing studies reveal that the female DUI offender is likely to:

- Be unmarried, separated or divorced (Wells-Parker, et al, 1991; Chang, Lapham & Barton, 1996)
- Unemployed and seeking employment (Wells-Parker, et al, 1991)
- Be drawn from wide age span (20-50) (Wells-Parker, et al, 1991)
- Be arrested secondary to a vehicular crash rather than for erratic driving (Waller & Blow, 1995).

Compared to young male DUI offenders, younger female DUI offenders are likely to exhibit greater alcohol, marijuana and tobacco use and report more strained relationships with their parents and parental disapproval of their friends (Farrow & Brissing, 1990).

Clinical classification differences exist between men and women arrested for DUI. Wells-Parker and colleagues (1991) found that 47.3% of female DUI offenders were classified as "high-problem-risk" compared to 57% of male DUI offenders. These figures underreport alcohol problems for both men and women due reliance on self-reported information whose validity is significantly compromised by fear of legal repercussions. A five-year follow-up study of convicted DUI offenders revealed that 85% of the female offenders (compared to 91% of male offenders) met lifetime criteria for alcohol abuse or alcohol dependence, and that 32% of female offenders (compared to 38% of male offenders) met lifetime criteria for a non-alcohol related substance use disorder (Lapham, Smith, C'de Baca, Chang, Skipper, Baum, & Hunt, 2001). A study of 1,105 DUI offenders in New Mexico found that of those with alcohol use disorders, 32% of females (compared to 38% of males) also had a drug use disorder and that 50% of women (compared to 33% of men) had an additional psychiatric diagnosis (Lapham, Smith, C'deBaca, Chang, Skipper, Baum & Hunt, 2001). These studies underscore the high percentage of female DUI offenders that are experiencing alcohol problems and the severity and complexity of those problems.

Few studies have compared the profiles of the male and female DUI recidivist. The best data available suggests the following:

- Male and female DUI recidivists are similar in ethnicity, levels of education, BAC at time of arrest, and lifetime substance use.
- Female recidivists reported higher rates of parental alcohol problems.
- Female recidivists reported higher rates of having hit or thrown something at their spouses (Lampham, Skipper, Hunt & Change, 2000).
- Younger female recidivist are more likely to share traits of rebellion and anti-social behavior similar to male DUI recidivists (Moore, 1994).

- Female recidivists have high rates of alcohol dependence and high rates of past year use of other psychotropic drugs (Lex, Sholar, Bower & Mendelsoln, 1991)

Given the limited number of studies available on female DUI offenders, we have highlighted below some of the broader studies on addiction, treatment and recovery among American women that have implications for the evaluation, treatment, sentencing and supervision of female DUI offenders.

Female Alcohol/Drug Physiology

There are pronounced differences between men and women related to the metabolism and physical effects of alcohol. Here are the key differences:

Metabolism: Women reach higher blood alcohol concentrations and become more impaired than men after drinking the same amounts of alcohol. This is related to the fact that women have lower mean body water volume than men (creating higher alcohol concentrations) and greater difficulties metabolizing alcohol (resulting from lower levels of the gastric alcohol dehydrogenase required in the metabolism of alcohol) (Lex, 1991; Blume, 1992; NIAAA, 1999).

Effect of Menstruation: Blood alcohol levels for women vary across phases of the menstrual cycle. Women report becoming most intoxicated before onset of menstrual flow and least intoxicated immediately after onset. Such variation is minimized for women taking oral contraceptives. The onset and intensity of binge drinking has also been linked to pre-menstrual distress (Rusell and Czarnecki, 1986).

Alcohol-related Medical Problems: Women develop alcohol-related physical problems faster than do men. Women develop alcohol-related liver disease (alcoholic hepatitis with and without cirrhosis), hypertension, anemia, gastrointestinal hemorrhage, and ulcers after shorter periods of drinking and at lower levels of alcohol intake than men. The risks for alcoholic cirrhosis and cancers of the head and neck are elevated for women who consume more than 2-5 drinks per day (Wilsnack, 1984; Gearhart, 1991; Gomberg, 1993). The medical risks of alcohol consumption extend beyond the woman herself. Fetal Alcohol Syndrome / Fetal Alcohol Effect (FAS/FAE) is a preventable form of developmental disability caused by excessive alcohol consumption during pregnancy.

Alcohol-related Mortality Rates: Alcohol dependent women have higher (50-100%) mortality rates than either non-alcoholic women or alcoholic men (Hill, 1986; Gomberg and Nirenberg, 1993). Primary causes of death for alcohol dependent women include diseases of the digestive and circulatory systems, accidents (particularly alcohol-sedative combinations), suicide and death by violence (Lex, 1991).

Incidence and Risk of Substance Use Disorders in Women

The Substance Abuse and Mental Health Service Administration's National Survey on Drug Use & Health defines substance dependence or abuse using criteria specified in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).* These criteria include such symptoms as recurrent drug or alcohol use resulting in physical danger, trouble with the law due to drug or alcohol use, increased tolerance to drugs or alcohol, and giving up or reducing other important activities in favor of drug or alcohol use. Based on the latest of these surveys, 5.9% of women aged 18 or older met criteria for abuse of or

dependence on alcohol or an illicit drug in the past year. 15.7% of females aged 18-25 and 26.3% of males aged 18 to 25 met criteria for either dependence or abuse. Among those aged 26 or older, males were twice as likely as females to be dependent on or abusing alcohol or an illicit drug. The rate of substance dependence or abuse for those age 50 or older was 4.9% for males and 1.5% for females (SAMHSA, 2005).

The higher rates of alcohol dependence for males was long thought to be based on greater genetic vulnerability for alcoholism among men, but recent studies of the heritability of alcoholism have concluded that a substantial (over 50%) of the risk of female alcoholism is genetically influenced (Kendler, et al., 1992; NIAAA, 1999). Many addicted women admitted to addiction treatment, particularly those entering through a DUI referral mechanism, present with multiple etiological factors: genetic risks related to intergenerational family histories of alcoholism, a history of physical and sexual abuse; a history of emotional deprivation, and anxiety and depression that make frequent mood alteration desirable; and involvement in intimate relationships and social groups that promote excessive drinking.

Onset of AOD Problems

Compared to men, the onset of alcohol and other drug problems in women occurs at a later age and is more likely to be associated with a particular life event (e.g., childbirth, breast removal, hysterectomy, family problems, divorce, physical or sexual assault, or the loss of a parent, spouse, or child through death (White, Woll & Webber, 2003; Beckman and Amaro, 1986).

Female Patterns of Substance Dependence

There are many clinically relevant gender differences in substance dependence. The course of alcohol and drug dependence in women is different than men in its symptomotology and is marked by a faster progression–the latter often referred to as "telescoping" (Smith and Cloninger, 1981). Such accelerated effects were first noted in women addicted to alcohol (Corrigan, 1980; Hesslebrock, et al., 1985; Stabenau, 1984). These early studies confirmed that women become physically addicted to alcohol more rapidly than men and with less volume of alcohol consumed (Spiegel, 1986). Later studies also discovered that women developed heroin addiction more quickly than men (Hser, et al., 1990). Studies of men and women addicted to cocaine reported women had earlier onset of use, higher rates of daily use, higher risk methods of ingestion (smoking or intravenous), more concurrent alcohol use, and an earlier age of entry into treatment (Griffin et al., 1989; Wechsberg, et al., 1998; McCance-Katz, et al., 1999). Seen as a whole, women entering addiction treatment have fewer years of substance use than their male counterparts, but present with great medical, psychiatric and social consequences of such use (Greenfield, et al, 2007).

In spite of the severe medical consequences of alcoholism in women, women alcoholics consume less alcohol that do male alcoholics and report less daily drinking and binge drinking (Blume, 1992). The phases of alcoholism are less distinct (Lisansky, 1957) and the symptoms and stages of alcoholism differ somewhat for women. Beginning with the work of James (1975), studies have documented that several early stage symptoms of alcoholism in men constitute late stage symptoms of alcoholism in women. For example men begin to choose substances over

relationships during early stages of problem development while women cling to relationships well into the alter stages of dependence.

Addicted women are more likely than men to be using other drugs in conjunction with beverage alcohol. They frequently present patterns of multiple concurrent and/or sequential drug use (Edwards, 1985; Celentano and McQueen, 1984). Multiple drug use places women at a higher risk for cross-addiction, toxic drug interactions and fatal overdoses.

Differences between male and female substance use patterns have been diminishing in recent years (Green, 2006).

Ethnic/Gender Differences

White, Woll & Webber (2003) reviewed the characteristics and consequences of addiction across ethnic groups and found substantial differences. African-American women tend to be clustered at the extremes of abstinence and heavy drinking, with more African American women totally abstaining than White women (Gary and Gary, 1985). Mexican-American women abstain from alcohol or drink moderately. While the pattern of alcohol abstinence has been consistently reported for immigrant Mexican American women, there are more recent reports of moderate and heavy drinking by Mexican-American women born in the U.S. (Caetano, 1985; Gilbert, 1987). Native American women experience the highest proportion of alcohol deaths. The alcoholic cirrhosis death rate for Native American women, ages 15-34, is 36 times the rate for White women; the rate for African-American women is 6 times the rate for White women (Malin, et al., 1978). The addictions literature is almost completely silent on the drug consumption patterns and problems of Asian-American women.

Addiction and Psychiatric Illness

Where addicted men are more likely to experience co-morbid personality disorders, addicted women are more likely to experience co-morbid affective disorders (Wilsnack, Wilsnack and Klassen, 1984). Addicted women are twice as likely to report major depression than addicted men (Wechsberg, et al., 1994) raising the potential that some women may self-medicate affective disorders with alcohol and other drugs. The co-occurrence of eating disorders (particularly bulimia) and substance use disorders has also been noted in the clinical literature (Katzman, et al., 1991; Holderness, et al., 1994). A 1996 NIMH-funded study of women detainees in Cook County Jail found that over 80% of the 1272 detainees met criteria for one or more lifetime psychiatric disorders. (*Arch Gen Psychiatry*/Vol 53).

Victimization as a Risk Factor

The relationship between childhood sexual abuse and/or subsequent sexual trauma and the onset and course of alcohol and other drug problems is a complex one. Key research and clinical findings include the following:

- Women with substance use disorders report higher rates of childhood sexual abuse compared to non-addicted women (67 percent compared to 28 percent) (Blume, 1992; Forth-Finnegan, 1991, 1984; Rachel, 1985; Covington, 1986), and reports of childhood

sexual abuse among addicted women seeking treatment range between 75-90 percent (Rohsenow, Corbett and Devine, 1988; Zweben, 1996).

- The link between developmental victimization and the subsequent development of substance use disorders may be intensified with the presence of key traumagenic factors, e.g., early onset of abuse, long duration of abuse, victimization by family members, multiple perpetrators, and failure to protect following early disclosure (White, Woll & Webber, 2003).
- Addicted women often present patterns of serial victimization–childhood sexual abuse followed by later episodes of physical and/or sexual assault (Miller, et al., 1989).
- Addicted women with histories of sexual victimization have a higher incidence of health problems and health care utilization than do addicted women without such histories (Liebbschultz, Mulvey and Samet, 1997).
- The sexual victimization of addicted women is often clinically nested within a larger cluster of problems, including feelings of depression, worthlessness, and powerlessness; suicidal thoughts; toxic, abusive intimate relationships, impaired mother-child relationships, and environmental chaos (Gomberg, 1993).
- The sexual abuse of addicted women may contribute to many of the clinical issues often noted in women's treatment programs: fear and distrust, shame and guilt, feelings of unworthiness; conflict about sex role identity; self-doubts about adequacy as a women; and sexual dysfunction (Wilsnack, 1973; Kirkpatrick, 1986).
- The preponderance of addicted women with a history of physical and sexual abuse suggests by itself the need for special approaches to their treatment (Skorine & Kovach, 1986).

It was long thought that a sexual abuse history was predictive of poorer treatment outcome, but this assumption is being challenged by recent studies. These studies note that women with sexual abuse histories report numerous problems (depression, anxiety, low self-esteem, low decision-making confidence) at treatment admission and at follow-up, but that they are more likely than women without such histories to consume less illicit drugs following treatment, be in counseling for psychological problems and to be taking psychotropic medications under the direction of a physician (Bartholomey, Courtney, Rowan-Szal & Simpson, 2005).

Obstacles to Treatment

The percentage of women entering addiction treatment is lower than the percentage of women in the general population who have substance use disorders (Greenfield, et al, 2007). Women encounter greater obstacles to initiating and completing treatment for a substance use disorder than do men (Green, 2006), although women may be more likely to seek help for substance use problems in general medical or psychiatric settings than specialty addiction treatment settings (Weisner & Schmidt, 1992). These obstacles include intense social stigma attached to addicted women (particularly addicted mothers), lack of support from intimate partners and family members, female socialization (e.g., learned helplessness, passivity), multiple role responsibilities, inadequate insurance and financial resources, fear of loss of custody of children and legal punishment (for pregnant, addicted mothers), and lack of child care, transportation and sober housing (NIAAA, 1983, Gomberg, 1988, Schliebner, 1994, Burman, 1992, Finkelstein, 1994)

Treatment Entry Decisions

There is growing evidence for gender-specific factors related to the initiation of recovery (e.g., pregnancy) and in obstacles to successful recovery (e.g., intimate involvement with an addicted husband or partner) (Anglin, et al., 1987). The entry of addicted women into treatment is associated with 1) perception of alcohol or drugs as a problem, 2) life events (consequences) that precipitate a crisis and need for change, 3) the anticipation or experience of hope that treatment can produce positive change, 4) the perception that the treatment agency has programs that can respond to her special needs and the needs of her family, and 5) a social network that supports entry and continued involvement in treatment (Thom, 1984). Waldorf (1983) found women separating from addicted husbands/paramours (often subsequent to their arrest) as a major factor in initiation of natural recovery in addicted women. Similarly, Wilsnack and her colleagues (1991) found divorce or separation associated with improved post-treatment outcomes among treated, married women (Wilsnak, et al., 1991).

Admissions of women to treatment have until recently been linked to health or family concerns (pregnancy, effect of use on children) than the occupational or legal issues that tend to bring men to treatment (Blume, 1992; Burmanm 1997). Pregnancy and/or concern about parental adequacy are major motivators for women seeking entry into addiction treatment (Rosenbaum and Murphy, 1990l Chen & Kandel, 1998), but the increased involvement of women in the criminal justice system has sparked a dramatic increase in women, particularly younger women, entering addiction treatment.

The use of indigenous outreach workers is effective in engaging women in addiction treatment who have previously resisted seeking out such services (Groos and Brown, 1993; White, Woll & Webber, 2003).

Female Treatment Admissions

Females made up 30% (565,400) of the 1.9 million addiction treatment admissions in the United States in 2002. Females admissions were an average of 33 years of age and were more likely to report problems with opiates or cocaine (fewer problems with alcohol or marijuana), be self-referred, be unemployed at admission, and more likely to be separated, divorced or widowed (DASIS Report, May 20, 2005).

Assessment and Treatment Process

The multiplicity of problems that characterize the lives of addicted women require a redesign of traditional evaluation and treatment processes. Assessment instruments and processes for addicted women need to be global as opposed to categorical and continuing rather than an intake activity (Wechsberg, 1995). The treatment itself needs to focus on the whole spectrum of problems presented by the addicted woman rather than focusing narrowly on the problem of addiction (Brown, Huba, and Melchior, 1995; Wechsberg, 1995). The nature and number of these problems may dictate a longer period of indicated treatment for women. For example, time and physical healing may be required for alcoholic women to recover from alcohol-induced neuropsychological deficits before intensive psychotherapies can be used effectively (Hill, in Wilsnack, 1984).

Traditional confrontational approaches in addiction treatment may be highly inappropriate and even injurious for many addicted women (Murray, 1989; Nelson-Zlupco, 1995; Zweben, 1996). Such traditional approaches require substantial modification for clinical appropriateness and effectiveness (Brown, et al., 1996). Motivational enhancement strategies offer a tested alternative to such clinical tactics (Miller and Rollnick, 1991).

In 1986, a sweeping review of the addiction treatment research concluded that there was little research evidence to support the efficacy of any particular treatment approaches for addicted women (Vannicelli, 1986). Since then, there has been an accumulation of research that is defining the major elements of an evidence-based, gender-specific and family focused model of addiction treatment. Women-specific addiction treatment programs differ significantly in the variety, comprehensiveness, design, duration and cost of services (Grella, et al., 1999). More specifically, they:

- provide outreach services (Reed, 1987)
- focus on addiction as one of multiple problems that require service attention (Nichols, 1985; Wallen, 1992; Zweben, 1996)
- collaborate with multiple helping agencies during the treatment process (Reed, 1987)
- concentrate services in a single, non-stigmatizing service environment (Kaplan-Sanoff and Leib, 1995; Finkelstein, 1993)
- focuses on the needs of the woman and her children
- treat gynecological and medical problems (Burman, 1992)
- provide child care, transportation and housing services (Beckman and Amaro, 1986)
- link clients to domestic violence services
- provide strong female recovery role models (DiMatteo and Cesarini, 1986; Reed, 1987),
- provide all-female groups and female therapists, outreach workers and case managers (Ruggels, et al., 1977; (Woodhouse, 1990)
- place emphasis on client empowerment via the goals of personal and economic self-sufficiency and an emphasis on choices throughout the treatment process (LaFave and Echols, 1998)
- provide women-only, peer support groups within the treatment milieu encouraging sexual autonomy related to desires, preferences, and limits (Nelson-Zlupko, 1995),
- provide case management services to address personal and environmental obstacles to recovery
- provide a longer duration of treatment involvement with a structured program of family-focused aftercare, and
- provide pregnancy-related services

Treatment Outcomes

Gender in and of itself is not a predictor of treatment outcome (Greenfiled, et al, 2007). Addiction treatment outcomes for women are influenced by both client characteristics and program characteristics (Morrissey, Ellis, Gatz, et al, 2005).

Women who complete treatment have nine times the abstinence rates as follow-up as women who did not complete treatment, whereas the abstinence rates of men completing treatment is only three times greater than men who do not complete treatment (Green, 2006).

In spite of the popular conceptions (myths) that women are hard to treat and have poor

treatment outcomes, early research suggested that women do as well as men in addiction treatment (Vannicelli, 1984; Annis & Liban, 1980; Toneatto et al, 1992). More recent studies have concluded that women have better post-treatment recovery outcomes than men (Walitzer & Dearing, 2000; McCance-Katz, Carroll &Rounsaville, 1999; Hser, Evans & Huang, 2005; Green, 2006). The latter findings included treatment outcome studies for cocaine and methamphetamine dependence.

Studies of women-only versus gender-mixed treatment programs have produced conflicting results, with some gender-specific programs showing enhanced outcomes (Dahlgren and Willander, 1989), while others revealed no difference in outcome (Copeland et al., 1993).

There is evidence that women-only treatment programs are able to reach those women that otherwise would not seek or complete addiction treatment (Reed and Leibson, 1981). What is most clear from treatment outcomes studies of women is that women have higher retention rates and better post-treatment outcomes in programs in which great numbers of women are treated and which provide a more comprehensive range of gender-specific services (Grella & Greenwell, 2004).

Poorer treatment outcomes for women have been associated with: 1) presence of a disturbed or violent parent during childhood, 2) depressive symptoms, 3) alcohol abuse and violence in partner at time of follow-up, 4) removal of children from home by authorities during follow-up period, and 5) problems handling aggressive impulses (Hover, 1986; Hover, 1987; Bergman, 1985; Walitzer & Dearing, 2000). Involvement with an addicted partner is a major etiological factor in the onset of excessive alcohol and drug use for women and a major barrier preventing the addicted woman from entering treatment or sabotaging her on-going recovery efforts (Lex, 1994). It should not be surprising, then that unmarried women have better post-treatment recovery rates than those who are married (McCrady and Raytek, 1993). Involvement in methadone treatment has been shown to provide structure and stability in the life of opiate-addicted women, but that many women of these women express concerns about the stigma related to their continued use of methadone (Rosenbaum and Murphy, 1990).

Three just-completed reviews of addiction treatment outcome studies on women (Sun, 2006; Greenfield, Brooks, Gordon, et al, 2006; Claus, et al, 2007) draw the following conclusions:

- Women with AOD problems are less likely to enter treatment than men with such problems.
- Treatment retention and completion rates are similar for women and men.
- Women as a group do better in residential modalities than modalities of lower intensity.
- Women do better in treatment programs that offer regular individual counseling in addition to non-confrontational group counseling.
- Retention and longer length of treatment is associated with better treatment outcomes for both men and women.
- Provision of child care services increases retention and the positive effects of treatment.
- Provision of case management services improves retention and outcomes.
- Women have better long-term outcomes following treatment than do men.
- Gender-specific treatment is effective, but study findings vary on the question of whether gender-specific treatment is more effective than mix-sexed treatment. Claus and colleagues (2007) conclude that “women admitted to women-only

programs have better retention and better outcomes relative to traditional mixed-gender programs" (p. 27).

Processes and Stages of Recovery

Women have shorter alcoholism careers. Fillmore (1987) found that heavy drinking for women peaked in their thirties and then dropped sharply during their forties and beyond, with a substantial number of women ceasing alcohol consumption after age 60. Fillmore concluded that, in comparison to men, remission of heavy drinking is more likely and more likely to occur earlier. There is further evidence that women have greater prospects for long-term recovery than do men. Humphreys and his colleagues found in a follow-up study of clients eight years post-discharge that women were 1.63 times more likely to be in stable recovery (Humphreys et al., 1997). Mohr, et al., (2001) attributes these enhanced outcomes to the fact that alcoholic women entering treatment have more non-drinking friends who are supportive of their recovery process than do alcoholic men. Recovery friendships and supportive social support networks are a significant motivator toward self-directed recovery for many women. The greater prospects of recovery may also extend to women addicted to drugs other than alcohol. Snow (1973) reported that women addicted to opiates had better long-term recovery rates than men with similar addiction patterns.

Recovery without Treatment/Moderated Recovery

Many young women aged 21-34, who as a group report the highest incidence of alcohol-related problems, will resolve these problems without treatment (Wilsnack, 1989). Such "natural recovery" (the achievement of recovery from addiction without the aid of professionally-directed treatment or sustained involvement in mutual aid groups) is more common in women than in men. In a recent study of natural recovery in women, Copeland (1998) found three themes in the resolution for change decisions: 1) concern for current and future health, 2) a lost sense of self, and 3) concern over the welfare of their children. Strategies that women use to self-manage their own recovery process include management of withdrawal, short-term drug substitution, severing drug-dominated intimate and social relationships, developing new social activities and relationships, and the cultivation of new health-promoting behaviors, e.g., nutrition, fitness, alternative medicine (Copeland, 1998). Those women who cannot achieve natural recovery when compared to those who do are found to have greater problem severity, greater psychiatric co-morbidity, and fewer family and social supports.

Gender differences are also noted in the literature about persons with alcohol problems who resolve such problems through moderating their use rather than by complete abstinence. Sanchez-Craig and her colleagues (1984, 1991) and others (Miller and Joyce, 1979; Elal-Lawrence, et al., 1986; Helzer, et al., 1985) have noted that women more likely than men to achieve successful moderation outcomes. Again, this may be related to the Mohr study (2001) findings that women had richer non-drinking social relationships than men and that such relationships enhanced not only successful abstinence but also served to lower the number of drinks per drinking day among those who did drink. Successful moderation is linked to lower personal vulnerability (e.g., absence of family history, later onset of alcohol/drug use), absence of co-occurring medical/psychiatric illness and significant family and social support (White &

Kurtz, in press).

Developmental Stages of Recovery

Recovery for most addicted women is a time-involved, developmental process. Confirming these observations was a recent study (Brown, et al., 2000) concluding that women may be at different stages of change for different problems, e.g., substance use, high risk sexual behaviors, violent relationships, child neglect, and that such change processes must be simultaneously managed. Relapse is often part of the early recovery process for many women. Such relapses can involve the primary drug to which the women was addicted or the use of secondary drugs. Willie (1978) reported that recovered heroin addicts used drugs such as alcohol and cannabis in the first year to cope with the challenges of early recovery. Willie framed such use not as substitute addiction but as an "intermediary stage" of recovery. Similar findings occurred in Copeland's (1998) study of natural recovery in women. All of the women noted to have developed an initial problem with a substituted drug later resolved this problem. While there is a very real danger of transferring dependencies e.g., from heroin to cocaine or alcohol, episodes of drug substitution are best seen as part of the early recovery process requiring active management than an indicator of either the untreatability of the client or the failure of a particular treatment method.

Recovery Support Structures

Women and cultural minorities affiliate with AA/NA at the same rates as White men (Humphreys, et al., 1994) and at least one report suggests that women may have an easier time affiliating with 12-step groups than do men (Denzin, 1987). This may be related to the fact that alcoholic women are more socially isolated (tell fewer individuals about their drug-related problems) and have less support from their partners for recovery (Bischof, et al., 2000). The percentage of women among AA members has increased from 15 percent in 1955 to 33 percent in 1996 (White, 1998). Special women's groups within AA grew during these same years. There are feminist-based alternatives to AA (Kirkpatrick, 1976), and AA's steps have been refined for greater applicability for women (Kasl, 1992; Lerner, 1990). There is also evidence that women, particularly African-American women, may use the church as a sobriety-based support structure (White, Woll & Webber, 2003).

Substance Use and Partner Violence

Alcoholic women tend to select mates who come from family backgrounds similar to their own (Rimmer & Winokur, 1972). This process is referred to as "assortative mating" (Lex, 1991) and has been linked to the victimization histories of addicted women. The research literature on addicted women portrays a picture of unstable marital/intimate relationships characterized by low levels of emotional satisfaction and increased levels of marital conflict that can escalate into the emotional/physical abuse of the alcoholic woman. This picture must be viewed in the context of the high rate of victimization of these clients. Research has confirmed the propensity of traumatized women to "repeat and re-enact subordination and victimization in their interpersonal attachments" (Bollerud, 1990). Breaking these cycles of victimization requires specialized treatment approaches (Herman and Schatzow, 1984).

Sentencing Issues

Few studies have distinguished the effectiveness of particular DUI sanctions by gender. One notable exception to this rule was a study of the effects of victim impacts panels on DUI recidivism. That study found that female repeat offenders who were referred to victim impact panels were twice as likely to recidivate as female repeat offenders not referred to a panel (C' De Baca, Lapham, Liang & Skipper, 2001). The authors suggested the possibility that victim impact panel could actually have a negative effect on the female repeat offender. The potential effectiveness or ineffectiveness of remedial education for the female DUI offender may well be an issue of timing. We suspect that early exposure to an impact panel may elicit too much empathy for women already steeped in self blame and may increase her risk of drinking due to shame and guilt, while introducing it later might prove beneficial.

Tips for Enhancing Recovery among Women

Police officers, evaluators, treatment specialists, prosecutors, judges, probation officers and Secretary of State Hearing Officers all have opportunities to interact with women who have driven under the influence of alcohol and who have significant alcohol and other drug related problems. These interactions offer tremendous opportunity to influence movement toward sustained recovery. In this section, we offer a few simple tips to reduce your stress, enhance your effectiveness, increase her accountability, and improve outcomes for addicted women.

Establish Rapport and Safety A helping alliance includes respect, rapport and safety. With histories of physical and or sexual abuse that spanned early developmental years through their adult lives, addicted women carry deeply embedded messages that the world is not a safe place, and that people, especially authority are cruel. Women in recovery talk about kindness from authority as if it were a rare and precious commodity. With harshness her anxiety level soars, she closes up and loses the capacity to hear you--she's frantically trying to defend herself. In an environment of safety and kindness she opens up and wants to comply with your expectations. Your stress level and hers will go down, and outcomes will improve.

Set Clear Expectations and Monitor Performance. Communicate in behavioral and measurable terms what is expected, acknowledge positive recovery-related activities and continue to monitor her compliance with positive feedback and support.

Convey Hope and Praise. Hope and affirmation are the lifeblood of recovery for women. Most addicted women have been socially stigmatized, victimized and blamed by systems they've reached out to. Hungry for approval from authority, acknowledging her positive efforts will motivate her and other women witnessing such praise. Recognizing and complimenting does not take a degree in counseling, but the payoff is tremendous.

Educate Yourself about the Stages of Recovery. We recommend several resources to enhance your education on the recovery process. The first is the book *Changing for Good* by John Prochaska, John Norcross and Carlo DiClemente, which demonstrates that timing in partnership with the appropriate intervention can interrupt addictive patterns. The second is an essay entitled

The Varieties of Recovery Experience by William White and Ernest Kurtz that is included in a monograph entitled Recovery Management that is distributed by the Great Lakes Addiction Technology Transfer Center. A third resource is an essay on the developmental stages of recovery for addicted women that summarizes a study of recovering women in Illinois' Project SAFE sites—an award winning program that treated women with histories of addiction-related abuse or neglect of their children. This essay is included as an appendix to this monograph.

Discover and Ignite Her Motivators Every woman will easily reveal what motivates her, when we set aside our own biases, values and beliefs. If you don't believe us, try this, for the next week, ask every woman you meet the same question, nothing deep or personal, but something as simple as

- Best birthday you ever had
- Something you enjoy

As she answers, she will reveal her values, beliefs, and motivators. Just as each woman has a unique face and personality, each possesses a unique set of values, beliefs, strengths, weaknesses and interests. By listening carefully you will discover her unique motivators and how to ignite those. She will easily share those ***when she feels safe, and when she feels heard.***

Help Each Client Increase Her Recovery Capital. Recovery capital is the internal and external resources that can be mobilized to initiate and sustain recovery. Here are examples of four categories of recovery capital:

- Social Capital – Social relationships that and encourage and support recovery.
- Physical Capital - Financial such as income, savings, a home, investments.
- Human Capital - Knowledge, skills, health, problem solving abilities.
- Cultural Capital - Beliefs, behavioral patterns, qualities that emanate from membership in a particular culture that encourage recovery.

We can help woman expand their recovery support resources by recognizing and enhancing their recovery capital, and suggesting simple assignments linked to her motivators. Here's an example of an assignment for a women who wanted to get her GED but suffered from testing anxiety.

- *Go to the library and request information on getting a GED. Don't sign up yet if you feel overwhelmed, just get the information.*
- *Ask women in AA who got their GED's in recovery to share when, where, how and any obstacles they overcame to get their GED.*

This assignment helps her understand the GED process and allows choices about when to begin. Studying for the GED builds confidence, enhances motivation and instills hope that she can learn, grow and change. Talking to other women helps build a recovery support network. These are examples of building recovery capital.

Where Possible, Shift Your Paradigm to "No Failure. Just Feedback" A key to ongoing recovery is the ability to explore what doesn't work and try new strategies. Relapses & acts of non-compliance can be important sources of feedback. Women in early recovery are suffering from the combined effects trauma, withdrawal and cognitive impairment of early recovery. Lake County and Cook County in Illinois both committed resources to establish specialized services for DUI Women and secured specialized training on gender specific models for their staff.

Rather than attributing deviant behavior as a product of personal failure, well trained staff will further assess and adapt approaches before imposing sanctions.

Visit Local Treatment Programs for Women. Visiting local treatment programs that have gender competent services for women will breathe life into the knowledge you've acquired about women and addictions. Collaboration improves treatment outcomes, eases the referral process for you, and will help you align your goals and her goals in treatment. Considering that women who complete treatment have nine times the abstinence rates as women who didn't complete treatment, it's well worth it to have a good working relationship with treatment programs.

Visit Open Recovery Support Meetings. We recommend acclimating yourself to local recovery support groups by reviewing literature and web sites of such groups (see www.facesandvoicesofrecovery.org, click mutual aid resources) and attending open meetings. You can contact AA (and often NA) through the Yellow Pages of the phone book. Your work will be enriched by hearing the powerful stories of women in long-term recovery whose lives, now meaningful and productive, were once as chaotic and problem-ridden as those of the women clients you now serve. Your ability to understand the core ideas, language and rituals of recovery groups will dramatically enhance your ability to link women to these groups and monitor their participation. You'll meet women today who are honest, hard working, reliable, a mother, wife, and friend, because someone just like you saw beyond their problems, held them accountable and encouraged them to hang in there for the miracle of recovery.

Attend Meetings And Hear Her Story Encourage current and former clients to invite you when they share their story at an open meeting. Most women will appreciate your interest and be proud to have you there. You will be surprised to learn new things about her as she pours out her truth the AA way. What you learn from her is sure to improve your interactions with other women on your case load.

Start a Women's Self Help Group In communities that do not have women's meetings of AA, NA, etc., you may want to help develop such a meeting by inviting AA / NA volunteers to start up meetings and conduct them. Developing such resources can be aided by working with current Hospital and Institution Committees within AA or NA or by setting up an AA/NA advisory group.

Explore Group Supervision Lake County, Illinois and Cook County, Illinois train their staff on conducting group supervision. Groups range from women's groups, co-ed groups and groups organized by severity/risk, groups for women who have reached abstinence, and those still struggling. Because women are very relationship oriented, they do very well in groups. But, because relapse is common in early recovery, groups for women who are still using get the best outcomes when staff is trained in women's issues, addiction interruption techniques, and running effective groups. Once mastered, these skills can be important recovery support resources, particularly in communities lacking women's groups in AA and NA.

Future Directions

Having reviewed the available research literature on women DUI offenders and the broader literature on the treatment of women and having interviewed women DUI offenders and those providing services to these women, we would offer the following ten recommendations related to enhancing the quality of evaluation, education, treatment and supervision of female DUI offenders in the State of Illinois.

1. Evaluation Instruments: Develop gender norms for existing evaluation instruments and/or develop an instrument or subscales based specifically on research with, at best, female DUI offenders, and at least, community and clinical samples of women.
2. Gender Competent Evaluators: Require all DUI evaluators to complete gender-specific training and hold IAODAPCA's forthcoming certificate for gender competence.
3. Recidivist Risk Profile: Develop a DUI recidivist risk profile that is based exclusively on research with women DUI offenders.
4. Gender-specific Risk Education: Audit and revise existing remedial education programs to assure gender competence. Segregate women into specialty groups when there are enough women.
5. Gender-specific DUI Treatment Models: Develop models for treating female DUI offenders that incorporate current research findings.
6. Gender-specific Treatment Specialty: Encourage the development of gender-specific DUI treatment services to assure enough referrals to organize women's groups.
7. Women's Recovery Support Groups: Develop a directory of women's recovery support groups in Illinois and that are available Online. Establish guidelines for establishing local liaison committees between the courts, treatment agencies and recovery mutual aid groups. Develop women's recovery support groups in communities where they do not exist. Recruit AA/NA volunteers to orient new judges, probation officers and other service roles to local recovery support groups.
8. Alumni Volunteers: Recruit, train and supervise a cadre of women in recovery who came through the DUI system who can serve as volunteer recovery coaches to women currently entering the system.
9. Consumer Feedback on Services: Conduct a survey of female DUI offenders to solicit feedback related to evaluation, treatment and probation services they have received.
10. Gender-research: Encourage all studies done on DUI in Illinois to analyze data for gender differences.

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References

Abbott, A.A. (1994). A feminist approach to substance abuse treatment and service delivery. *Social Work in Health Care*, 19(3/4), 67-83.

Abdel-Aty, M.A. & Abdelwahab, H.T. (2000). Exploring the relationship between alcohol and the driver characteristics in motor vehicle accidents. *Accident Analysis and Prevention*, 32, 473-482.

Alderden, Megan, Lurigio, Arthur J., and Olson, David E. (2003). Men Are From Mars, Women Are From Venus, But What Role Does Gender Play in Probation Recidivism? Justice Research and Statistics Association.

Amaro, H., Beckman, L.J., and Mays, V.M. (1987). Comparison of black and white women entering alcoholism treatment. *Journal of Studies on Alcohol*, 48(3): 220-228.

Amaro, H. and Hardy-Fanta, C. (1995). Gender relations in addiction and recovery. *Journal of Psychoactive Drugs*, 27: 325-337.

Anderson, C.M., Teicher, M.H., Polcari, A., Renshaw, P.F. (2002). Abnormal T2 relaxation time in the cerebellar vermis of adults sexually abused in childhood: potential role of the vermis in stress-enhanced risk for drug abuse. *Psychoneuroendocrinology*, 27(1-2): 231-244.

Anderson, S.C. and Henderson, D.C. (1985). Working with lesbian alcoholics. *Social Work*, 30(6): 518-525.

Anderson, B. and Zinsser, J. (1981). *A History of Their Own: Women in Europe from Prehistory to the Present*. New York: Harper and Row, pp. 14-15.

Annis, H. and Liban, C. (1980). Alcoholism in women: Treatment modalities and outcomes. In O. Kalant, (Ed.), *Alcohol and Drug Problem in Women: Research Advances in Alcohol and Drug Problems*. Vol. 5, (pp. 385-422). New York: Plenum Press.

An Assessment of the Needs of and Resources for Children of Alcoholic Parents. (1974). (Report commissioned by the National Institute on Alcohol Abuse and Alcoholism). Rockville, MD: National Institute on Alcohol Abuse and Alcoholism (Booz-Allen & Hamilton).

Babcock, M. and Connor, B. (1981). Sexism and treatment of the female alcoholic: A review. *Social Work*, pp. 233-238.

Bandura, A. (1973). *Aggression: A Social Learning Analysis*. Englewood Cliffs, New Jersey: Prentice-Hall, Inc.

Bartholomew, N.G., Courtney, K., Rowan-Szal, G.A., & Simpson, D.D. (2005). Sexual abuse history and treatment outcomes among women undergoing methadone treatment, *Journal of Substance Abuse Treatment*, 29, 231-235.

Bauman, P.S. and Dougherty, F.E. (1983). Drug addicted mothers': Parenting and their children's development. *International Journal of the Addictions*, 18(3): 291-302.

Beckman, L. J. (1976). Alcoholism problems and women: An overview. In M. Greenblatt & M. Schuckit (Eds.), *Alcoholism Problems in Women and Children*. New York: Grune & Stratton.

Beckman, L.J. (1978). Self-esteem of women alcoholics. *Journal of Studies on Alcohol*, 39: 491-498.

Beckman, L.J. (1978). Sex-role conflict in alcoholic women: Myth or reality. *Journal of Abnormal Psychology*, 87: 408-417.

Beckman, L.J. (1984). Analysis of the suitability of alcohol treatment resources for women. *Substance and Alcohol Actions/Misuse*, 6(1): 21-27.

Beckman, L. and Amaro, H. (1984/85). Patterns of women's use of alcohol treatment agencies. *Alcohol Health & Research World*, Winter, pp. 15-25.

Beckman, L. and Amoro, H. (1986). Personal and social difficulties faced by women and men entering alcoholism treatment. *Journal of Studies on Alcohol*, 47: 135-145.

Beckman, L.J. (1984). Treatment needs of women alcoholics. *Alcoholism Treatment Quarterly*, 1(2): 101-114.

Beckman, L. J. (1975). Women alcoholics: A review of social and psychological studies. *Journal of Studies on Alcohol*, 36: 797-824.

Beckman, L. J. and Amaro, H. (1984). Patterns of women's use of alcohol treatment agencies. In S. Wilsnack and L. (Eds.), *Alcohol Problems in Women: Antecedents, Consequences, and Intervention*. New York: Guilford Press.

Beckman, L. J. and Kocel, K.M. (1982). Treatment-delivery system and alcohol abuse in women: Social policy implications. *Journal of Social Issues*, 38(2): 139-151.

Behnke, M., Eyler, F. D., Garvan, C. W., Wobie, K. (2001). The Search for Congenital Malformations in Newborns With Fetal Cocaine Exposure. *Pediatrics*, 107: 74e-74.

Belfer, M.L., Shader, R.I., Carroll, M., and Harmatz, J.S. (1971). Alcoholism in women. *Archives of General Psychiatry*, 25: 540-544.

Bennett, L. & Williams, O. (1999). Men who batter. In R. Hampton et al. (Eds.) *Family Violence: Prevention and Treatment*, (2nd Edition, pp. 227-259). Thousand Oaks CA: Sage Publications Inc.

Bergman, H; Bergman, I. (1985). Psychological characteristics of female alcoholic patients with early alcohol problems during treatment and two years later: /1/. *Proceedings of the 31st International Institute on the Prevention and Treatment of Alcoholism: Volume I*, Rome, Italy: 2 Jun – 7 Jun 1985. 495 p. (pp. 182-197).

Biernacki, P. (1986). *Pathways from heroin addiction: Recovery from treatment*. Philadelphia, PA: Temple University Press.

Bingol, N, et. Al. (1987). Teratogenicity of cocaine in human. *Journal of Pediatrics*, 110: 93-96.

Black, C. (1979). Children of alcoholics. *Alcohol Health and Research World*, 4(1): 23-27.

Black, C. (1981). *It will never happen to me*. Denver, M.A.C.

Black, R. & Mayer, J. (1980). Parents with special problems: Alcoholism and opiate addiction. *Child Abuse and Neglect*, 4: 45.

Blume, S. (1994). Gender differences in alcohol-related disorders. *Harvard Review of Psychiatry*, 2: 7-14.

Blume, S. B. (1992). Alcohol and other drug problems in women. In J. H. Lowinson, P. Ruiz, R. B. Millman (Eds.), & J. G. Langrod (Assoc. Ed.), *Substance abuse* (2nd Ed.), pp. 794-807. Baltimore, MD: Williams & Wilkins.

Blume, S. (1991). Women, Alcohol, and Drugs. In: N. Miller (Ed.) *Comprehensive Handbook of Drug and Alcohol Addiction*. NY: Dekker, pp. 147-177.

Blume, S. B. (1990). Chemical dependency in women: Important issues. *American Journal on Drug Alcohol Abuse*, 16(3&4): 297-307.

Blume, S. (1988). *Alcohol/drug dependent women: New treatment insights into their special problems, treatment, recovery*. Minneapolis, MN: Johnson Institute.

Blume, S. (1986). Women and alcohol: A review. *Journal of the American Medical Association*, 256(11): 1467-1470.

Blume, S. B. (1986). Women and alcohol: Public policy issues. In *Women and Alcohol: Health Related Issues*. NIAAA Research Monograph No. 16, Rockville, MD: National Institute on Alcohol Abuse and Alcoholism.

Bohman, M., Sigvardsson, S., and Cloninger, C.R. (1981). Maternal inheritance of alcohol abuse. *Archives of General Psychiatry*, 38: 965-969.

Bollerud, K. (1990). A model for the treatment of trauma-related syndromes among chemically dependent inpatient women. *Journal of Substance Abuse Treatment*, 7.

Bourgeois, M., Levigneron, M., and Delage, H. (1975). The children of alcoholics: A study of 66 children of alcoholics in a child psychiatry service. *Annales Medico-Psychologiques*, 2(3): 592-609.

Bradley, K., Boyd-Wickizer, J., Powell, S., and Burman, M. (1998). Alcohol Screening Questionnaires in Women: A critical review. *Journal of the American Medical Association*, 280: 171.

Braiker, H.B. (1982). Diagnosis and Treatment of Alcoholism in Women. In *Special Population Issues*. NIAAA Research Monograph No. 4, Washington, DC: US Government Printing Office (pp.111-139).

Brenner, B. (1967). Alcoholism and fatal accidents. *Quarterly Journal of Studies on Alcohol*, 28(3): 517-528.

Brindis, C.D., Clayson, Z., and Berkowitz, G. (1997b). Options for recovery: California's perinatal projects. *Journal of Psychoactive Drugs*, 29(1), 89-99.

Brown, V.B., Melchior, L.A., Panter, A.T., Slaughter, R., and Huba, G.L. (2000). Woman's steps of change and entry into drug abuse treatment: A multidimensional stages of change model. *Journal of Substance Abuse Treatment*, 18: 231-240.

Brown, S. (1985). *Treating the alcoholic: A developmental model of recovery*. Wiley Series on Personality Processes, New York, NY: John Wiley & Sons.

Brown, V.B, Huba, G.J., and Melchior, L.A. (1995). Level of burden: Women with more than one-co-occurring disorder. *Journal of Psychoactive Drugs*, 27: 339-346.

Brown, V.B., Sanchez, S., Zweben, J.E., and Aly, T. (1996). Challenges in moving from a traditional therapeutic community to a women and children's TC model. *Journal of Psychoactive Drugs*, 28(1): 39-46.

Burman, S. (1992). A model for women's alcohol/drug treatment. *Alcoholism Treatment Quarterly*, 9(2): 87-99.

Busch, D., McBride, A.B., and Benaventura, L.M. (1986). Chemical dependency in women: The link to ob/gyn problems. *Journal of Psychosocial Nursing and Mental Health Services*, 24(4): 26-30.

Bushway, D. and Heiland, L. (1995). Women in treatment for addiction: What's new in the literature? *Alcoholism Treatment Quarterly*, 13(4): 83-96

Bushway, D.J. (1991). Chemical dependency treatment for lesbians and their families: The feminist challenge. *Journal of Feminist Family Therapy*, 3(3): 161-172.

Caetano, R. (1985). Drinking patterns and alcohol problems in a national sample of U.S. Hispanics. In: D. Spiegler, D. Tate, Aitken, S., Christian, C. (Eds.), *Alcohol Use Among U.S. Ethnic Minorities: Proceedings of a Conference on the Epidemiology of Alcohol* Use *and Abuse Among Ethnic Minority Groups, September 1985*. NIAAA Research Monograph No. 18. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism, 1989, (pp 147- 162).

Cappell, C. and Heiner, R. B. (1990). The intergenerational transmission of family aggression. *Journal of Family Violence*, 5: 135-152.

Carlson, B.E. (1984). Children's observations of interparental violence. In A. R. Roberts (Ed.), *Battered women and their families*, (pp. 147-167), New York: Springer.

Carroll, J. F. X., Malloy, T. E., Roscioli, D. L., Pindjak, G. M., and Clifford, J. S. (1981). Personality similarities and differences in four diagnostic groups of women alcoholics and drug addicts. *Journal of Studies on Alcohol*, 42: 432-440.

Carten, A. J. (1996). Mothers in recovery: rebuilding families in the aftermath of addiction. *Social Work*, 4(2): 214-223.

Celentano, D. D. and McQueen, D. V. (1984). Multiple substance use among women with alcohol-related problems. In S. C. Wilsnack & L. J. Beckman (Eds.), *Alcohol problems in women* (pp 97-116). New York: Guilford Press.

Centers for Disease Control (2001). Infant Mortality Statistics from the 1999 Period Linked Birth/Infant Death Data Set. *National Vital Statistics Report* 50 (4).

Chang, G., Carroll, K. M., Behr, H. M., & Kosten, T. R. (1992). Improving treatment outcome in pregnant opiate-dependent women. *Journal of Substance Abusing Treatment*, 9: 327-330.

Chang, I., Lapham, S.C. & Barton, K.J. (1996). Drinking environment and sociodemographic factors among DUI offenders. *Journal of Studies on Alcohol*, November, pp. 659-669.

Chase, James Hadley (1951). *The Marijuana Mob*. New York: Eton Books.

Chasnoff, I., Chisum, G. & Kaplan, W. (1988). Maternal cocaine use and genitourinary tracts malformations. *Teratology*, 37: 201-204.

Chavez, G. F., Mulinare, J. and Codero, J. (1989). Maternal cocaine use during pregnancy as a risk factor for congenital urogenic anomalies. *Journal of the American Medical Association*, 262: 795-798.

Chavkin, W. (2001). Cocaine and pregnancy: Time to look at the evidence. *Journal of the American Medical Association*, 285(12): 1626-1628.

Child Welfare League of America (1998). *Alcohol and Other Drug Survey of State Child Welfare Agencies*. Washington, DC: Child Welfare League of America.

Child Welfare League of America North American Commission on Chemical Dependency (1992). *Children at the front: A different view of the war on alcohol and drugs.* Washington, D.C.: Child Welfare League of America.

Chiriboga, C. A., Brust, J. C. M., Bateman, D. and Hauser, W. A. (1999). Dose-Response effect of fetal cocaine exposure on newborn neurologic function. *Pediatrics*, 103(1): 79-85.

Claus, R.E., Orwin, R.G., Kissin, W., et al, (2007). Does gender-specific substance abuse treatment for women promote continuity of care? *Journal of Substance Abuse Treatment*, 32, 27-39.

Chopra, K. S., Preston, D. A., and Gerson, L. W. (1979). Effect of constructive coercion on the rehabilitative process. *Journal of Occupational Medicine*, 21(11): 749-752.

Christopherpoulos, C., Cohn, A. D., Shaw, D. S., Joyce, S., Sullivan-Hanson, J., Kraft, S. P., & Emery, R. E. (1987). Children of abused women: I. Adjustment at time of shelter residence. *Journal of Marriage and the Family*, 49: 611-619.

Cocaine Exposure. Pediatrics,107: 74e-74

Coletti, S. D., Schinka, J. A., Hughes, P. H., Hamilton, N. L., Renard, C. G., Sicilian, D. M., and Neri, R. L. (1997). Specialized therapeutic community treatment for chemically dependent women and their children. In G.DeLeon (Ed.), *Community as a method:*

therapeutic communities for special populations and special settings. Westport, CT: Praeger/Greenwood Publishing Group.
Collins, J.J. (1989). Alcohol and interpersonal violence: less than meets the eye. In: *Pathways to criminal violence.* N. A. Weiner and M. A. Wolfgang (eds.) Newbury Park CA: Sage Publications.
Collins, J.J. & Messerschmidt, P.M. (1993). Epidemiology of alcohol-related violence. *Alcohol Health and Research World*, (17) 2: 93-100.
Comfort, M., Zanis, D. A., et al. (1999). Assessing the needs of substance abusing women. *Journal of Substance Abuse Treatment*, 17(1-2): 79-83.
Copeland, J. (1998). A qualitative study of self-managed change in substance dependence among women. *Contemporary Drug Problems*, 25(Summer): 321-345.
Copeland, J., Hall, W., Didcot, P., and Biggs, V. (1993). A comparison of a specialist women's alcohol and other drug treatment service with two traditional mixed-sex services: Client characteristics and treatment outcomes. *Drug and Alcohol Dependence*, 32: 81-92.
Copeland, J. and Hall, W. (1992). A comparison of women seeking drug and alcohol treatment in a specialist women's and two traditional mixed-sex treatment services. *Br. J. Addict.* 87: 1293-1302.
Corrigan, E. M. & Anderson, S. C. (1982). Black alcoholic women in treatment. *Focus on Women: Journal of Addictions and Health*, 3.
Corrigan, E. M. (1980). *Alcoholic Women in Treatment.* New York: Oxford University Press.
Covington. S. (1994). *A Woman's Way Through the Twelve Steps*. Center City, MN: Hazelden.
Covington, S. S. (1991). Sororities of helping and healing: Women and mutual help group. *Alcohol and Drugs are Women's Issues.* Paula Roth (Ed.) Metuchen, NJ: Women's Action Alliance and the Scarecrow Press.
Covington, S. (1985). Chemically dependent women and sexuality. *Proceedings of the 31st International Institute on the Prevention and Treatment of Alcoholism: Volume 1*, Rome, Italy: 2 June – 7 June.
Covington, S. S. (1986). Facing the Clinical challenges of women alcoholics: Physical, Emotional and sexual abuse. *Focus on Family*, 9(3): 10-11, 37, 42-44.
Covington, S. S. (1986). Misconceptions about women's sexuality: Understanding the influence of alcoholism. *Focus on Family and Chemical Dependency*, 9(2): 6-7, 44.
Cross, T. (1997). *Heritage and Helping. A Model Curriculum for Indian Child Welfare Practice*. Portland: Indian Child Welfare Association.
Crothers, T.D. (1878). Inebriety in women. *Quarterly Journal of Inebriety*, 2: 247-248.
Curlee, J. (1969). Alcoholism and the "empty nest". *Bulletin of the Menninger Clinic*, 33: 165-171.
Curlee, J. (1970). A comparison of male and female patients at an alcoholism treatment center. *Journal of Psychologv*, 74: 239-247.
Cuskey, W. and Wathey, R. (1982). *Female addiction*. Lexington, MA: Lexington Books.
Dahlgren, L. and Willander, A. (1989). Are special treatment facilities for female alcoholics needed? A controlled 2-year follow-up study from a specialized female unit (EWA) versus a mixed male/female treatment facility. *Alcoholism: Clinical and Experimental Research*, 13: 499-504.
Davis, D.J. (1990). Prevention issues in developing programs. In R.C. Engs (Ed.) *Women: Alcohol and Drugs*. Dubuque, IA: Kendall/Hunt Publishing Company.

Davis, S. (1994). Drug treatment decisions of chemically-dependent women. *The International Journal of the Addictions*, 29(10): 1287-1304.

Dept of Transportation (US), National Highway Traffic Safety Administration (NHTSA). Traffic safety facts 2003: overview. Washington (DC): NHTSA; 2004b [cited 2004 Oct 19]. Available from URL: www-nrd.nhtsa.dot.gov/pdf/nrd-30/NCSA/TSF2003/809767.pdf.

Dimatteo, T. E. & Cesarini, T. M. (1986). Responding to the treatment needs of chemically dependent women. *Journal of Counseling and Development*, 64: 452-453.

Douglas, J. J. Pesheau, G. (1985). Evaluation of an inpatient women's addiction treatment program. Alcohol, Drugs and Tobacco: An International Perspective. Past, Present and Future. *Proceedings of the 34th International Congress on Alcoholism and Drug Dependence: Volume II.* Papers, Calgary, Alberta, Canada: 4 Aug – 10 Aug 1985 (pp. 214-216).

Driving Under the Influence Among Adult Drivers (2005). The National Survey on Drug Use and Health, July 1, 2005.

Drugged Driving: 2002 Update. (2003). The National Survey on Drug Use and Health Report, September 16, 2003.

Dutton, D. and Painter, S. L. (1981). Traumatic bonding: The development of emotional attachments in battered women and other relationships of intermittent abuse. *Victimology*, 6: 13-23.

Edwards, D.W. (1985). Investigation of the use and abuse of alcohol and other drugs among 50 aged male alcoholics and 50 aged female alcoholics. *Journal of Alcohol and Drug Education*, 30(2): 24-30.

Eldred, C. A. and Washington, M. N. (1975). Interpersonal relationships in heroin use by men and women and their role in treatment outcome. *International Journal of the Addictions*, 11(1): 117-130.

Engs, R. C. (Ed.) (1990). *Women: Alcohol and other drugs*. Dubuque, IA: Kendall/Hunt Publishing Company.

Estep, R. (1987). Influence of the family on the use of alcohol and prescription depressants by women. *Journal of Psychoactive Drugs*, 19(2): 171-179.

Eyler, F. D., Behnke, M., Conlon, M., Woods, N. S., Wobie, K. (1998). Birth outcome from a prospective, matched study of prenatal crack/cocaine use: I. Interactive and dose effects on health and growth. *Pediatrics*, 101: 229-236.

Fagan, Jeffrey (1993). Set and setting revisited: influences of alcohol and illicit drugs on the social context of violent events. *Alcohol and interpersonal violence: fostering multidisciplinary perspectives*. Research Monograph 24, pp. 161-191. Rockville, MD: NIAAA.

Farrow, J.A. & Brissing, P. (1990). Risk for DWI: A new look at gender differences and drinking and driving influences, experiences, and attitudes among new adolescent drivers. *Alcohol Education Quarterly*, 17(2), 213-221.

Feinberg, F. (1995). Substance abusing mothers and their children: treatment for the family. In L. Combrink-Graham (Ed.), *Children in families at risk.* New York: Guilford.

Finkelstein, N. (1993). Treatment programming for alcohol and drug-dependent pregnant women. *International Journal of Addictions*, 28(13): 1275-1309.

Finkelstein, N. (1994). Treatment issues for alcohol and drug dependent pregnant and parenting women. *Health and Social Work*, 19(1): 7-13.

Finkelstein, N. and Derman, L. (1991). Single parent women: What's a mother to do? In P. Roth (Ed.), *Alcohol and drugs are women's issues* (pp. 78-84). New York: Scarecrow Press.
Finnegan, D.G. and McNally, E.B. (1988). *Dual identities: Counseling chemically dependent gay men and lesbians*. Center City, MN: Hazelden.
Forth-Finegan, J. (1991). Sugar and spice and everything nice: Gender socialization and women's addiction: A literature review. In C. Bepko (Ed.), *Feminism and addiction* (pp.19-48). New York: Haworth Press.
Fox, V. (1979). Clinical experiences in working with women with alcoholism. In Vasanti Burtle (Ed.), *Women Who Drink*. Springfield, IL: Charles C. Thomas Publishers, pp. 119-126.
Frank, D. A., Augustyn, M., Knight, W. G., Pell, T. and Zuckerman, B. (2001). Growth, development, and behavior in early childhood following prenatal cocaine exposure: A systematic review. *Journal of the American Medical Association*, 285(12): 1613-1625.
Gary, L. E. and Gary, R. B. (1985-86). Treatment needs of black alcoholic women. *Alcoholism Treatment Quarterly*, 2(3): 97-114.
Gearhart, J., Beebe, D., Milhorn, H. and Meeks, R. (1991). Alcoholism in women. *American Family Physician*, 44(3): 907-913.
Geller, J. and Harris, M. (1994). *Women of the Asylum: Voices From Behind the Walls, 1840-1945*. NY: Doubleday.
Gilbert, J. (1987). Alcohol consumption patterns in immigrant and later generation Mexican American women. *Hispanic Journal of Behavioral Sciences*, 9(3).
Gilligan, Carol. (1982). In A Different Voice. Cambridge, MA.Harvard University Press.
Grella, C.E. & Greenwell, L. (2004). Substance abuse treatment for women: Changes in the settings where women received treatment and types of services provided, 1987-1998. *The Journal of Behavioral Health Services & Research*, 31(4), 367-383.
Gomberg, E.S.L. (1993). Gender issues. In M. Galanter (Ed.), *Recent Developments in Alcoholism*, 11: 95-107. New York: Plenum.
Gomberg, E.S.L. & Nirenberg, T.D. (1993). Antecedents and consequences. In E.S.L. Gomberg, and T.D. Nirenberg (Eds.), *Women and substance abuse*. Norwood, NJ: Ablex.
Gomberg, E.S.L. (1991). Alcoholic women in treatment: New research. *Substance Abuse*, 12(1).
Gomberg, E.S.L. (1989a). Alcoholic women in treatment: Use of other drugs. *Alcoholism: Clinical and Experimental Research*,13: 338.
Gomberg, E.S.L. (1989). Alcoholism in women: Use of other drugs. *Alcoholism: Clinical and Experimental Research*, 13(2): 338.
Gomberg, E.L. (1988). Alcoholic women in treatment: The question of stigma and age. *Alcohol and Alcoholism*, 23: 507-514.
Gomberg, E.S.L. (1986). Women: Alcohol and other drugs. *Drugs and Society*, 1(1): 75-109.
Gomberg, E.S.L. (1986). Women with alcohol problems. In N.J. Estes and M.E. Heinemann, *Alcoholism: Development, Consequences, and Interventions*. Third Edition. St. Louis, MO: C.V. Mosby Company.
Gomberg, E. S. (1974). Women and alcoholism. In V. Franks and V. Burtle, (Eds.), *Women in Therapy*. New York: Brunner/Mazel.
Gomberg, E. S. Alcoholism in women. In B. Kissin and H. Begleiter, (Eds.) *The Biology of Alcoholism, Vol. IV*. New York: Plenum Press.
Gomberg. E.L. (1987). Shame and guilt issues among women alcoholics. *Alcoholism Treatment Quarterly*, 4(2): 139-155.

Gomberg, E. (1980). Risk factors related to alcohol problems among women: proneness and vulnerability. In: Alcoholism and Alcohol Abuse Among Women: Research Issues. Proceedings of a Workshop, April 2-5, 1978, Jekyll Island, Georgia. NIAAA Research Monograph No. 1, Rockville, MD: National Institute on Alcohol Abuse and Alcoholism (pp. 83-118).

Goodman, G. and Rosenberg, M. (1987). *The Child Witness to Family Violence*, In Sonkin, D. (Ed.): *Domestic Violence on Trial: Psychological and Legal Dimensions of Family Violence*, New York, Springer.

Granfield, R. and Cloud, W. (1999). *Coming Clean: Overcoming Addiction Without Treatment.* New York: New York University Press.

Green, C.A. (2006). Gender and use of substance abuse treatment services. *Alcohol Research & Health*, 29(1), 55-62.

Greenblatt, M. and Schuckit, M. (1976). *Alcoholism Problems in Women and Children*. New York: Grune & Stratton,

Greenfield, L.A. (1998). *Alcohol and crime: An analysis of national data on the prevalence of alcohol involvement in crime*. Report prepared for the Assistant Attorney General's National Symposium on Alcohol and Crime. Washington, DC: U.S. Department of Justice Conference.

Greenfield, S.F., Brooks, A.J., Gordon, S.M., et al. (2007). Substance abuse treatment entry, retention, and outcome in women: A review of the literature. *Drug and Alcohol Dependence*, 86, 1-21.

Grella, C., Polinsky, M., Hser, Y. and Perry, S. (1999). Characteristics of women-only and mixed-gender drug abuse treatment programs. *Journal of Substance Abuse Treatment,* 17(1-2): 37-44.

Griffin, M.L., Weiss, R.L., Mirin, S.M., Lange, U. (1989). A comparison of male and female cocaine abusers. *Archives of General Psychiatry*, 46: 122-126.

Gross, M. & Brown, V. (1993). Outreach to injection drug-using women. In B.S. Brown, G.M. Beschner (Eds.), *Handbook on risk for AIDS: Injection drug users and their sexual partners*. Westport, CT: Greenwood Press.

Hagen, T., Finnegan, L., and Nelson-Zlupko, L. (1994). Impediments to comprehensive treatment models for substance-dependent women: Treatment and research questions. *Journal of Psychoactive Drugs*, 26: 163-171.

Hagan, T. (1987). A retrospective search for the etiology and drug abuse: A background comparison of a drug-addicted population of women and a control group of non-addicted women. In L.S. Harris (Ed.), *Problems of drug dependence 1987*, (pp. 254-261). Rockville, MD: National Institute on Drug Abuse.

Hall, J.M. (1993). What really worked? A case analysis and discussion of confrontational intervention for substance abuse in marginalized women. *Archives of Psychiatric Nursing*, 7: 322-327.

Hall, L. (1888). Inebriety in Women: Its Causes and Results. *Quarterly Journal of Inebriety*, 5: 223-224.

Haller, D.L. Kinsely, J.S., Dawson, K.S., and Schnoll, S.H. (1993). Prenatal substance abusers psychological and social characteristics. *The Journal of Nervous and Mental Disease,* 181(8): 509-513.

Halliday, A., Bushn, B., Cleary, P., Aronson, M., and Delbanco, T. (1986). Alcohol abuse in women seeking gynecologic care. *Obstetrics and Gynecology*, 68(3): 322-326,

Harrison, P.A. and Belille, C.A. (1987). Women in treatment: Beyond the stereotype. *Journal of Studies on Alcohol*, 48(6): 574-578.

Haskett, M.E., Miller, J.W., Whitworth, J.M., and Huffman, J.M. (1992). Intervention with cocaine-abusing mothers. *Families in Society*, 451-462.

Hatsukami, D., Owen, P.L. (1980). Treatment outcome in female alcoholics: A new perspective. Center City, MN: Hazelden Foundation.

Haver, B. (1987). Female Alcoholics: IV. The Relationship Between Family Violence and Outcome 3-10 Years After Treatment. (University of Bergen, Department of Psychiatry, Bergen, Norway). *Acta Psychiatrica Scandinavica*, 75(5): 449-455.

Haver, B. (1987). Female Alcoholics: III. Patterns of Consumption 3-10 Years After Treatment. (University of Bergen, Department of Psychiatry, Bergen, Norway). *Acta Psychiatrica Scandinavica*, 75(4): 397-404.

Haver, B. (1986). Female Alcoholics: I. Psycho-social Outcome Six Years After Treatment. (University of Bergen, Haukeland Hospital, Bergen, Norway). *Acta Psychiatrica Scandinavica*, 74(1): 102-111.

Haver, B. (1986). Female Alcoholics: II. Factors Associated With Psycho-social Outcome 3-10 Years After Treatment. (Rutgers – The State University of New Jersey, Center for Alcohol Studies, Piscataway). *Acta Psychiatrica Scandinavica*, 74(6): 597-604.

Haver, B. (1985). Treatment outcome in female alcoholics: Findings from a long term follow-up study of 44 women. Alcohol, Drugs and Tobacco: An International Perspective. Past, Present and Future. *Proceedings of the 34th International Congress on Alcoholism and Drug Dependence: Volume II.* Papers, Calgary, Alberta, Canada: 4 August – 10 August, (pp. 523-515).

Haver, B. (1986). DSM-III diagnosis of alcohol use disorders in women: Findings from a follow-up study of 44 female alcoholics. (University of Bergen, Department of Psychiatry, Bersen, Norway). *Acta Psychiatrica Scandinavia*, 73: 22-30.

Heiser, K. and Hartmann, U. (1987). Disorders of sexual desire in a sample of women alcoholics. *Drug and Alcohol Dependence*, 19: 145-157.

Hennessey. Maya D. (1996). Women and Substance Abuse: From Denial to Recovery. *Bar Leader*.

Hennessey, Maya (1997). Substance Abusing Women… Is It a Fault or a Flight From the Past? *Women's Self Defence Magazine*.

Hennessey, Maya. (2005). Just For Women: Cook County Jail Women's Justice Services. Heartland Journal.

Herd, D. (1988). Drinking by black and white women: Results from a national survey. *Social Problems*, 35(5): 493-505.

Herman, J. and Schatzow, E. (1984). Time-limited group therapy for women with a history of incest. *International Journal of Group Psychiatry*, 144: 908-915.

Herrington, R.E., Jacobson, G.R., and Benzer, D.G. (Eds). (1987). *Alcohol and drug abuse handbook*. St. Louis, MO: Warren H. Green, Inc.

Hesselbrock, M.N., Meyer, R.E., and Keener, J.J. (1985). Psychopathology of hospitalized alcoholics. *Archives of General Psychiatry*, 42: 1050-1055.

Hesselbrock, M.N. (1981). Women alcoholics: A comparison of the natural history of alcoholism between men and women. In: *Evaluation of the Alcoholic: Implications for Research, Theory, and Treatment*. NIAAA Research Monograph No. 5. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism.

Hill, S.Y. (1984). Vulnerability to the biomedical consequences of alcoholism and alcohol-related problems among women. In *Alcohol Problems in Women: Antecedents, Consequences, and Intervention*, New York, NY: Guilford Press,. (pp. 121-154).

Hill, S.Y. (1986). Physiological effects of alcohol in women. In: *Women and Alcohol: Health Related Issues.* Proceedings of a Conference, May 23-24, 1984. NIAAA Research Monograph No. 16, Rockville, MD: National Institute on Alcohol Abuse and Alcoholism, (pp. 199-214).

Hinchey, F. S., & Gavelek, J. R. (1982). Empathic responding in children of battered women. *Child Abuse and Neglect*, 6: 395-401.

Holck, S.E., Warren, C., Smith, J. and Rochat, R. (1984). Alcohol Consumption among Mexican-American and Anglo Women: Results of a survey along the U.S. Mexico Border. *Journal of Studies on Alcohol*, 45: 149-153.

Horgan, C., Rosenbach, M., Ostby, E., and Butricea, B. (1990). *Targeting Special Populations with Drug Abuse Problems: Pregnant Women and Infants.* Unpublished draft manuscript. Waltham, Massachusetts: Bigel Institute for Health Policy, Brandeis University.

How Women Recover (1982-83). *Alcohol Health and Research World*, 7(2): 28-40.

Howard, J. and Beckwith, L. (1996). Issues in subject recruitment and retention with pregnant and parenting substance-abusing women. In E.R. Rahdert (Ed.), *Treatment for drug-exposed women and their children: advances in research methodology.* NIDA Research Monograph (Vol. 165). Rockville, MD: National Institute on Drug Abuse.

Hser, Y.I., Anglin, M.D., and Powers, K. (1990). Longitudinal patterns of alcohol use by narcotics addicts. In: M. Galanter (Ed.), *Recent Developments in Alcoholism, Volume 8. Combines Alcohol and Other Drug Dependence*. New York: Plenum Press.

Hser, Y., Evans, E. & Huang, Y. (2005). Treatment Outcomes among Women and men methamphetamine abusers in California. *Journal of Substance Abuse Treatment*, 28, 77-85.

Hughes, H. M. (1988). Psychological and behavioral correlates of family violence in child witness and victims. *American Journal of Orthopsychiatry*, 58: 77-90.

Hughes, H.M., Parkinson, D. and Vargo, M. (1989). Witnessing spousal abuse and experiencing physical violence: A "double whammy?" *Journal of Family Violence*, 4: 197-209.

Hyman, H. (1976). Alcoholics 15 years later. *Annals of the New York Academy of Sciences*, 273: 613-622.

Illinois Department of Children and Family Services (1999). *Substance Affected Families Policy and Practices Training: Trainers Guide*. IDCFS: Springfield, IL.

Ingersoll, K., Dawson, D., and Haller, D. (1996). Family functioning of perinatal substance abusers in treatment. *Journal of Psychoactive Drugs*, 28(1): 61-71.

Jacobson, M., Atkind, R., and Hacker, G. (1983). *The Booze Merchants: The Inebriating of America.* CSPI Books: Washington, D.C.

Jaffe, P., Wolfe, D., Wilson, S., & Zak, L. (1986). Similarities in behavioral and social maladjustment among child victims and witnesses to family violence. *American Journal of Orthopsychiatry*, 56: 142-146.

Johnson, F.W., Gruenewald, P.J. & Treno, A. (1998). Age-related differences in risk of drinking and driving in gender and ethnic groups. *Alcoholism: Clinical and Experimental Research*, 22(9), 2013-2022.

Johnson, L. (1843). *Martha Washingtonianism: A History of the Ladies' Temperance Benevolent Societies*. Boston: Saxton, Peirce & Company.

Johnson, J.L. and Leff, M. (1999). Children of substance abusers: Overview of research findings. *Pediatrics*, 103(5): 1085-1099.

Johnson, S. (1991). Recent Research: Alcohol and Women's Bodies. In: Roth, P. *Alcohol and Drugs Are Women's Issues*. London: Scarecrow Press.

Johnston, L.D., O'Malley, P.M. & Bachman, J.G. (1987). National trends in drug use and related factors among American high school students young adults, 1975-1986. National Institute on Drug Abuse: Rockville, MD.

Johnston, L. D., O'Malley, P. M., Bachman, J. G., & Schulenberg, J. E. (2006). *Monitoring the Future national results on adolescent drug use: Overview of key findings, 2005* (NIH Publication No. 06-5882). Bethesda, MD: National Institute on Drug Abuse, 67 pp.

James, J.E. (1975). Symptoms of alcoholism in women: A preliminary study of A.A. members. *Journal of Studies on Alcohol*, 36: 1564-1578.

Jones, B.M. and Jones, M. (1976). Women and alcohol: Intoxication, metabolism and the menstrual cycle. In *Alcoholism Problems in Women and Children*, (Eds.) M. Greenblatt and M.A. Schuckit. New York: Grune and Stratton.

Jones, B.M. and Jones, M.K. (1976). Alcohol effects on women during the menstrual cycle. *Annals of the New York Academy of Sciences*, 273: 576-587.

Jones, K., Smith, D., Ulleland, C., and Streissguth, A. (1973). Pattern of Malformation in Offspring of Chronic Alcoholic Mothers. *Lancet*, 1: 1267-1271.

Jones-Saumty, D., Fabian, M., Parsons, O. (1981). Medical status and cognitive functioning in alcoholic women. *Alcoholism: Clinical and Experimental Research*, 5(3): 372-377.

Jones, T.R., Smith, R.S., Martier, S., Dombrowski, M.P. and Sokol, R.J. (1994). *Alcohol and drug use in pregnancy: Effects on the Offspring.* In: Miller, N (Ed.) *Principles of Addiction Medicine.* Chevy Chase, MD: American Society of Addiction Medicine.

Kandall, S. (1996). *Substance and Shadow: Women and Addiction in the United States*. Cambridge, MA: Harvard University Press.

Kaplan-Sanoff, M., and Lieb, S.A. (1995). Model intervention programs for mothers and children impacted by substance abuse. *School Psychology Review*, 24(2): 186-199.

Karpman, B. (1956). *The Alcoholic Woman: Case Studies in the Psychodynamics of Alcoholism*. Washington DC: The Linacre Press.

Kaskutas, L. (1994). What do Women Want out of Self-Help? Their Reasons for Attending Women for Sobriety and Alcoholics Anonymous. *Journal of Substance Abuse Treatment*, 11(3): 186.

Kaskutas, L.A. (1996). Pathways to self-help among Women for Sobriety. *American Journal of Drug and Alcohol Abuse*, 22(2): 259-280.

Kasl, C. (1992). *Many Roads, One Journey: Moving Beyond the 12 Steps.* New York: Harper Perennial.

Kasl, C. (1989). *Women, Sex, and Addiction.* New York: Harper & Row.

Kaufman-Kantor, G. and Straus, M. (1987). The "drunken bum" theory of wife beating. *Social Problems*, 34(3):214-231.

Kelley, M. (1899). Women and the Drink Problem. *The Catholic World*, 69: 678-687.

Kendler, K., Heath, A., Neale, M., Kessler, R., and Eaves, L. (1992). A population-based twin study of alcoholism in women. *Journal of the American Medical Association*, 268(14): 1877-1882.

Kerouac, S., Taggart, M.E., Mescop, J. and Fortin, M.F. (1986). Dimensions of health in violent families. *Health Care for Women International*, 11: 413-426.

Kessler, R.C., Michelson, K.D. and Zhao, S. (1997). Patterns and Correlates of Self-Help Group Membership in the United States. *Social Policy*, Spring 27-46.
Kirkpatrick, J. (1986). *Goodbye Hangovers, Hello Life.* New York: Ballantine Books.
Kirkpatrick, J. (1981). *A Fresh Start*. Dubuque: Kendall/Hunt Publishing.
Kirkpatrick, J. (1978). *Turnabout: Help for a New Life*. Garden City, NY: Doubleday and Company.
Klassen, A.D. and Wilsnack, S.C. (1986). Sexual experience and drinking among women in a U.S. national survey. *Archives of Sexual Behavior,* 15: 363-392.
Kominars, S.B. (1989). *Accepting ourselves: The twelve step journal of recovery from addiction for gay men and lesbians*. New York: Harper & Row.
Kosten, T.R., Rounsaville, B.J., & Kleber, H.D. (1986). A 2.5 year follow-up of treatment retention and reentry among opioid addicts. *Journal of Substance Abuse Treatment,* 3: 181-189.
Kovach, J.A. (1986). Incest as a treatment issue for alcoholic women. *Alcoholism Treatment Quarterly*, 3(1):1-15.
Krauthamer, C. (1974). The personality of alcoholic mothers and their children: A study of their relationship to birth-order, mother-child attitude, and socioeconomic status. *Dissertation Abstracts International*, 1974, 34, 5198B. (Abstract)
Krauthamer, C. (1979). Maternal attitudes of alcoholic and nonalcoholic upper middle class women. *International Journal of the Addictions*, 14: 639-644.
Kritsberg, W. (1985). *The Adult Children of Alcoholics Syndrome*. New York: Bantam Books.
Kumpfer, K.L., Hofman, A. (1986). Family Issues in Women's Alcoholism Treatment. *National Council on Alcoholism Forum*, 18 April – 21 April, San Francisco, California.
LaFave, L.M. (1999). An argument for choice: An alternative women's treatment program. *Journal of Substance Abuse Treatment*, 16(4): 345-352.
LaFrance, S.V., Mitchell, J., Damus, K., Driver, C., Roman, G., Graham, E., & Schwartz, L. (1994). Community-based services for pregnant substance-using women. *American Journal of Public Health,* 84(10): 1688-1689.
Lapham, S. C., Smith, E., C'de Baca, J., Chang, I., Skipper, B. J., Baum, G., & Hunt, W. C. (2001). Prevalence of psychiatric disorders among persons convicted of driving while impaired. *Archives of General Psychiatry, 58*(10), 943-949.
Leland, J. (1984). Alcohol use and abuse in ethnic minority women. In S. Wilsnack & L. Beckman (Eds.), *Alcohol problems in women.* New York: Guilford Press, 66-96.
Leonard, K.E. & Blane, H.T. (1992). Alcohol and marital aggression in a national sample of young men. *Journal of Interpersonal Violence*, 7(1): 19-30.
Leonard, K.E. & Quigley, B.M. (1999). Drinking and marital aggression in newlyweds: An event-based analysis of drinking and the occurrence of husband aggression. *Journal of Studies on Alcohol*, 60(4): 537-545.
Lerner, H.G. (1990-Spring). 12-stepping it: Women's roads to recovery. A psychologist tells why. *Lilith.*
Leshner, A. (1995) Filling the gender gap in drug abuse research. NIDA Notes, 10(1): 2-3.
Lewis, C.E., Saghir, M.T. & Robins, E. (1982) Drinking patterns in homosexual and heterosexual women. *Journal of Clinical Psychiatry,* 43: 277-279.
Lex, B.W. (1991). Some gender differences in alcohol and polysubstance users. *Health Psychology,* 10(2): 121-132.

Lex, B.W. (1994). Alcohol and other drugs among women. *Alcohol Health and Research World*, 18(3): 212-219.

Lex, B.W.,, Sholar, J.W., Bower, T. & Mendelson, J.H. (1991). Putative Type II Alcoholism Characteristics in Female Third DUI Offenders in Massachusetts: A Pilot Study. *Alcohol*, (8) 283-287.

Lieber, C. (1993). Women and alcohol: Gender differences in metabolism and susceptibility. In E. Gomberg and T. Nirenberg, (Eds.) *Women and substance abuse*. Norwood, NJ: Ablex Publishing, pp 1-17.

Liebschultz, J.M., Mulvey, K.P, & Samet, J.H. (1997). Victimization among substance-abusing women: Worse health outcomes. *Arch Intern Med*, 157(10): 1093-1097.

Lindbeck, V.L. (1972) The woman alcoholic: A review of the literature. *International Journal of the Addictions*, 7(3): 567-580.

Lockheed, M.E., & Hall, K.P. (1976). Conceptualizing sex as a status characteristic: Applications to leadership training strategies. *Journal of Social Issues*, 32: 11-124.

Luthar, S.S., & Walsh, K.G. (1995). Treatment needs of drug addicted mothers: Integrating parenting psychotherapy interventions. *Journal of Substance Abuse Treatment*, 12(5): 341-348.

MacDonald, J.G. (1987). Predictors of Treatment outcome for alcoholic women. *International Journal of the Addictions*, 22(3): 235-248,

Magura, S., & Laudet, A.B. (1996). Parental substance abuse and child maltreatment: review and implications for intervention. *Child and Youth Services Review*, 18(3): 193-220.

Malin, H.H., Archer, L.D., & Munch, N.E. (1978). A national surveillance system for alcoholism and alcohol abuse. Paper presented at the 32nd International Congress on Alcoholism and Drug Dependence, Warsaw, Poland, September 3-8, 1978. (Also Alcohol Epidemiologic Data System Working paper No. 8, Rockville, MD).

Maril, R. & Zavaleta, N. (1979). Drinking patterns of low-income Mexican American women. *Journal of Studies on Alcohol*, 40(5).

Marlatt, G.A. & Rohsenow, D.J. (1980). Cognitive processes in alcohol use: Expectancy and the balanced placebo design. In: N.K. Mello, (Ed.), *Advances in Substance Abuse Behavioral and Biological Research*, Greenwich, CN: Jai

Martin, S.E. (1992). The epidemiology of alcohol-related interpersonal violence. *Alcohol Health and Research World*, (16)3: 230-237.

Martin, S.E. (1993). Introduction. Alcohol and interpersonal violence. Fostering multidisciplinary perspectives. *Research Monograph 24*, National Institute on Alcoholism and Alcohol Abuse, 16(3):

Marsh, J.C. & Miller, N.A. (1985). Female clients in substance abuse treatment. *The International Journal of the Addictions*, 20(6&7): 995-1019.

Mayer, J., and Black, R. (1976). The relationship between alcoholism and child abuse/neglect. Paper presented at the Seventh Annual Medical – Scientific Session of the National Council on Alcoholism Forum. Washington, D.C., May, 1976.

Mayes, L.C., Granger, R.H. Bornstein, M.H., & Zuckerman, B. (1992). The problem of prenatal cocaine exposure: A rush to judgement. *Journal of the American Medical Association*, 267: 406-408.

McCance-Katz, Carroll, K., & Rounsaville, B.J. (1999). Gender differences in treatment-seeking cocaine abusers: Implications for treatment and prognosis. *The American Journal on Addictions*, 8: 300-311.

McCrady, B.S., & Raytek, H. (1993). Women and substance abuse: Treatment modalities and outcomes. In. E.S. Gomberg, & T.D. Nirenberg (Eds.), *Women and substance abuse* (Pp 314-348). Norwood, NJ: Ablex.

McCrady, B.S. (1984). *Women and Alcoholism*. New York, New York: Guilford Press, (pp. 428-449).

McGirr, K.J. (1975). Alcohol use and abuse in the gay community: A view toward alienation. In K. Jay & A. Youth (Eds.), *After you're out.* New York: Pyramid Books.

McKay, M. (1994). The link between domestic violence and child abuse: Assessment and treatment considerations. *Child Welfare League of America*, 73: 29-39.

McKirnan, D.J. & Peterson, P.L. (1989) Alcohol and drug use among homosexual men and women: Epidemiology and population characteristics. *Addictive Behaviors*, 14(5): 545-553.

Midanik, L. (1983). Familial alcoholism and problem drinki8ng in a national drinking practices survey. *Addictive Behavior*, 8: 113-141.

Miller, B.A., Downs, W.R., & Testa, M. (1993). Interrelationships between victimization experiences and women's alcohol use. *Journal of Studies on Alcohol*, 11: 109-117.

Miller, B.A., Downs, W.R. and Gondoli, D.M. (1989). Espousal violence among alcoholic women as compared to a random household sample of women. *Journal of Studies on Alcoholism*, 50(6): 533-540.

Miller, D. and Jang, M. (1977). Children of alcoholics: A 20 year longitudinal study. *Social Work Research and Abstracts*, 13(4): 23-29.

Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior*. New York: Guilford Press.

Moise, R., Reed, B.G., and Conell, C. (1981). Women in drug abuse programs: Factors that influence retention at very early and later stages in two treatment modalities: A summary. *International Journal of the Addictions*, 16(7).

Moore, R.H. (1994). Underage female DUI offenders: Personality characteristics, psychological stressors, alcohol and other drug use, and driving risk. *Psychological Reports*, (74, 435-445.

Morrissey, J.P., Ellis, A.R., Gatz, M. et al, (2005). Outcomes for women with co-occurring disorders and trauma: Program and person-level characteristics. *Journal of Substance Abuse Treatment*, 28, 121-133.

Morningstar, P. and Chitwood, D. (1987). How women and men get cocaine: sex role stereotypes and acquisition patterns. *Journal of Psychoactive Drugs*, 19: 135-142.

Mosbacher, D. (1988). Lesbian Alcohol and Substance Abuse. *Psychiatric Annals*, 18(1): 47-50.

Murray, J. B. (1989). Psychologists and alcoholic women. *Psychology Reports*, 64(2): 627-644.

Musto, D. (1973). *The American Disease: Origins of Narcotic Controls.* New Haven: Yale University Press.

Nelson-Zlupko, L., Kauffman, E., and Dore, M.M. (1995). Gender differences in drug addiction and treatment: implications for social work interventions with substance-abusing women. *Social Work*, 40(1): 45-51.

NIAAA (1990). *Alcohol and Health. 7th Special Report to the U.S. Congress.* Washington, DC: U.S. Government Printing Office.

Nichols, M. (1985). Theoretical concerns in the clinical treatment of substance abusing women: A feminist analysis. *Alcoholism Treatment Quarterly*, 2(1): 79-90.

NIDA (1991). *Annual Emergency Room Data: 1991*. National Institute on Drug Abuse Statistical Data Series 1, Number 11-A. Rockville, MD: NIDA.

NIDA (1999). NIDA Research Report: Cocaine Abuse and Addiction. National Institute on Drug Abuse, Rockville, MD: NIDA

Nielsen, L.A. (1984). Sexual abuse and chemical dependency: Assessing the Risk for women alcoholics and adult children. *Focus on Family and Chemical Dependencv*, 7(6): 6, 10-11, 37.

Northstar Project. (1991). *Out and counted: A survey of the Twin cities gay & lesbian community*. Minneapolis: Gay & Lesbian Community Action Council.

O'Neill, Eugene (1956) *Long Day's Journey into Night*. New Haven: Yale University Press.

Orme, T.C., & Rimmer, J. (1981). Alcoholism and child abuse: A review. *Journal of Studies on Alcohol*, 42, 273-287.

Osofsky, J. and Fenichel, E. [Eds.] (1994). *Caring for Infants and Toddlers in Violent Environments: Hurt, Healing and Hope*. Zero to Three/National Center for Infant Clinical Programs, Arlington, VA.

Parker, R.N. & Rebhun, L.A. (1995). *Alcohol and homicide: A deadly combination of two American traditions*. Albany: State of New York Press.

Parks, K.A., Nochajski, T.H., Wieczorek, W.F. & Miller, B.A. (1996). Assessing alcohol problems in female DWI offenders. *Alcoholism: Clinical and Experimental Research*, 20(3), 434-439.

Pernanen, Kai (1981). Theoretical aspects of the relationship between alcohol use and crime. In: J.J. Collins, (Ed.) *Drinking and crime: perspectives on the relationship between alcohol consumption and criminal behavior*. New York: Guilford Press.

Pernanen, Kai (1991). *Alcohol in human violence*. New York: Guilford Press.

Pfouts, J.H., Schopler, J.H., Henley, H.C. (1982). Forgotten victims of family violence. *Social Work*, 27(4): 367-368.

Practical approaches in the treatment of women who abuse alcohol and other drugs. (1994). Rockville, MD: Center for Substance Abuse Prevention, DHHS.

Prochaska, J.O., DiClemente, C.C., & Norcross, J.C. (1992). In search of how people change: application to addictive behaviors. *American Psychologist*, 47: 1102-1114.

Popkin, C.L. (1991) Drinking and driving by young females. Accident Analysis and Prevention, 23(1), 37-44.

Rachel, V. (1985). Woman like you: Life stories of women recovering from alcoholism and addiction. New York, NY: Harper and Row Publishers.

Ramlow, B.E., White, A.L., Watson, D.D., and Leukefeld, C.G. (1977). The needs of women with substance use problems: An expanded vision for treatment. *Substance Use and Misuse*, 32(10): 1395-1404.

Rathbone-McCuan, E., & Roberds, L. (1980). A treatment of the older female alcoholic. *Focus on Women*, 1: 104-129.

Reed, B.G. (1987). Developing women-sensitive drug dependence treatment services: Why so difficult? *Journal of Psychoactive Drugs,* 19(2):151-164.

Reed, B.G. (1985). Drug misuse and dependency in women: The meaning and implications of being considered a special population or minority group. *International Journal of the Addictions*, 20: 13-62.

Reed, B. and Leibson, E. (1981). Women clients in special women's demonstration drug abuse treatment programs compared with women entering selected co-sex programs. *International Journal of the Addictions*, 16(8): 1425-1466.

Rimmer, J. (1974). Psychiatric illness in husbands of alcoholics. *Quarterly Journal of Studies on Alcohol*, 35: 281-283.

Robinson, S.D. (1984). Women and alcohol abuse: Factors involved in successful interventions. *International Journal of the Addictions*, 19(6): 601-611.

Robsenow, D.J., Corbett, R., & Devine, D. (1988). Molested as children: A hidden contribution to substance abuse. *Journal of Substance Abuse Treatment*, 5: 13-18.

Roizen, J. (1997). Epidemiologcal issues in alcohol-violence. In M. Galanter (Ed)., *Recent developments in alcoholism, vol. 13: Alcoholism and violence*. New York: Plenum Press.

Roman, P.M. (1988). *Women and Alcohol Use: A Review of the Research Literature*. U.S. Department of Health and Human Services: Rockville, MD.

Rorabaugh, W. (1979). *The Alcoholic Republic: An American Tradition.* Oxford: Oxford University Press

Rosenbaum, M. & Murphy, S. (1990). Women and addiction: Process, treatment, and outcome. NIDA Research Monograph Series 98, The Collection and Interpretation of Data from Hidden Populations. Rockville, MD: U.S. Department of Health & Human Services, National Institute on Drug Abuse.

Rosenbaum, M. and Murphy, S. (1981). Getting the treatment: Recycling women Addicts. *Journal of Psychoactive Drugs*, 13(1): 1-13.

Rosenbaum, A. and O'Leary, D. K. (1981). Children: The unintended victims of marital violence. *American Journal of Orthopsychiatry*, 51: 692-699.

Roth, P. (1991). *Alcohol and Drugs are Women's Issues.* Metuchen, NJ: Women's Action Alliance and Scarecrow Press (2 volumes).

Rounsaville, B.J., Tierney, T., Crits-Christoph, K., Weissman, M.M., and Kleber, H.D. (1982). Predictors of outcome in treatment of opiate addicts. *Comprehensive Psychiatry*, 23: 462-478.

Roy, M. (1988). *Children in the crossfire: Violence in the home-How does it affect our children?* Deerfield, FL: Health Communications.

Ruggels, W. L., Mothershead, A., Pyszka, R., Loebel, M., and Lotridge, J. (1977). *A Follow-up Study of Clients at Selected Alcoholism Treatment Centers Funded bY NIAAA* (supplemental report). Menlo Park, CA: Stanford Research Institute.

Russell, M. and Czarnecki, D. (1982). Alcohol use and menstrual problems [Abstract]. *Alcoholism: Clinical and Experimental Research*, 10:99.

Russell, M., Lyons, J.P, Brown, J. (1981). Development of a self-administered questionnaire to screen for alcoholism in females. *Alcoholism: Clinical and Experimental Research*, 5(1): 166.

SAMHSA (1997). *Substance use among women in the United States*. Office of Applied Studies, Analytical Series A-3: Rockville, MD

SAMHSA (2001a). *Drug Abuse Warning Network: Detailed Emergency Department (ED) Tables: 2000*. Office of Applied Studies, Analytical Series ___. Rockville, MD: Substance Abuse and Mental Health Services Administration.

SAMHSA (2001b). *Summary of findings from the 2000 national household survey on drug abuse*. Office of Applied Studies, Analytical Series H-13: Rockville, MD.

SAMHSA (2001c). How men and women enter treatment. *The DASIS Report, August 3, 2001*. Office of Applied Studies, Substance Abuse and Mental Health Services Administration: Rockville, MD.

Sandmaier, M. (1980) The Invisible Alcoholics: Women and Alcohol Abuse in America. New York: McGraw-Hill Book Company.

Saville, P.D. (1975). Alcoholism-Related Skeletal Disorder. *Annals of the New York Academy of Science*, 252, 287.

Sax. Leonard. (2005) Why Gender Matters. What Parents and Teachers Need To Know About The Emerging Science of Sex Differences. Doubleday. Division of Random House.

Schaefer, S., Evans, S., Sterne, M. (1985). Incest among women in recovery from alcoholism and drug dependency: Correlation and implication for treatment. Alcohol, Drugs and Tobacco: An International Perspective, Past, Present and Future. *Proceedings of the 34th International Congress on Alcoholism and Drug Dependence: Volume II.* Calgary, Alberta, Canada: 4 August – 10 August, pp. 268-269.

Schatzkin, A. et al. (1987). Alcohol Consumption and Breast Cancer in the Epidemiologic Follow-up Study of the First National Health and Nutrition Examination Survey. *New England Journal of Medicine*, 316: 1169-1173.

Schliebner, C. (1994). Gender-sensitive therapy: An alternative for women in substance abuse treatment. *Journal of Substance Abuse Treatment*, 11(6): 511-515.

Schmidt, L. and Weisner, C. (1995). The emergence of problem-drinking women as a special population in need of treatment. In M. Galanter (Ed.), *Recent Developments in Alcoholism, Vol 12: Alcoholism and women* (pp309-334). New York: Plenum Press.

Schuckit, M.A., & Morrissey, E.R. (1976). Alcoholism in women: Some clinical and social perspectives with an emphasis on possible subtypes. In M. Greenblatt & M.A. Schucket (Eds.), *Alcoholism Problems in Women and Children*. New York: Grune & Stratton.

Schuckit, M. (1972). The alcoholic woman: A literature review. *Psychiatry in Medicine*, 3(11): 37-43.

Schuckit, M.A., Pitts, F.M., Reich, T., King, L.J., & Winokur, G. (1969). Alcoholism: I. Two types of alcoholism in women. *Archives of General Psychiatry*, 20: 301-306.

Schuckit, M.A., and Winokur, G. (1969). A Short Term Follow Up of Women Alcoholics. *Diseases of the Nervous Svstem*, 33: 672-678.

Sclare, A. B. (1970). The female alcoholic. *British Journal of Addiction*, 65: 99-107.

Semidei, J., Radel, L.F., and Nolan, C. (2001). Substance abuse and child welfare: clear linkages and promising responses. *Child Abuse and Neglect*, 80(2): 109-128.

Skorina, J.K., Kovach, J.A. (1986). Treatment techniques for incest-related issues in alcoholic women. *Alcoholism Treatment Quarterly*, 3(1): 17-30.

Smith, A. (1986). Alcoholism and Gender: Patterns of Diagnosis and Response. *Journal of Drug Issues*, 16(3): 407-420.

Smith, E.M. & Cloninger, C.R. (1981). Alcoholic females: Mortality at twelve-year follow-up. *Focus on Women: Journal of Addictions and Health*, 2: 1-13.

Smith, H. (1901). Alcohol in Relation to Women. *Quarterly Journal of Inebriety*, 23: 190-193.

Smith, L.M., Chang, L., et al. (2001). Brain Proton Magnetic Resonance Spectroscopy and Imaging in Children Exposed to Cocaine in Utero. *Pediatrics*, 107: 227-231.

Snell, T.L., & Morton, D.C. (1991). *Women in Prison: Survey of State Prison Inmates*. Bureau of Justice Statistics Special Report NCJ-145321. Washington, DC: U.S. Department of Justice, Office of Justice Statistics, Bureau of Justice Statistics.

Sparks, A. (1898). Alcoholism in Women. *Medical Record*, 1898, 52: 699-701.
Sparks, A. (1898). Alcoholism in Women: Its Causes, Consequence, and Cure, *Quarterly Journal of Inebriety* 20 (1898): 31-37.
Stabenau, J.R. (1984). Implication of family history of alcoholism, antisocial personality, and sex differences in alcohol dependence. *American Journal of Psychiatry*, 141: 1178-1182.
Stark, E. & Flitcraft, A. (1988). Violence among intimates: An epidemiological view. In: V.D. Van Hasselt, R.L. Morrison, A.S. Bellack, & M. Herson, (Eds.), *Handbook of Family Violence*. New York: Plenum.
Sterk, C. (1999). *Fast Lives: Women Who Use Crack Cocaine.* Philadelphia: Temple University Press.
Stets, J.E. (1990). Verbal and physical aggression in marriage. *Journal of Marriage and Family*, 43: 721-732.
Stevens, S.J. & Arbiter, N. (1995). A therapeutic community for substance- abusing women and women with children: Process and Outcome. *Journal of Psychoactive Drugs*, 27(1): 49-56.
Strantz, I.H. and Welch, S.P. (1995). Postpartum women in outpatient drug abuse treatment: correlates of retention/completion. *Journal of Psychoactive Drugs*, 27(4): 357-373.
Straus, M.A. and Gelles, R.J. (Eds.) (1990). Physical violence in American families. New Brunswick, NJ: Transaction Publishers.
Straus, M.A. (1991). *Children as witness to marital violence: A risk factor for life long problems among a nationally representative sample of American men and women*. Paper presented at the Ross Roundtable on A Children and Violence, Washington, D.C., September 1991.
Strauss, M.E., et al. (1975). Behavior of narcotics-addicted newborns. *Child Development*, 46: 887-893.
Substance Abuse and Mental Health Services Administration. (2005). *Results from the 2004 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NSDUH Series H-28.
Sutker, P.E. (1982). Acute alcohol intoxication: Mood changes and gender. Paper presented at the 13th Annual Medical-Scientific Conference of the National Alcoholism Forum, Washington, D.C., (April).
Swan, Neil (1998). Exploring the role of child abuse in later drug abuse: Researchers face broad gaps in information. *NIDA Notes, 13 (2).* Rockville, MD: National Institute on Drug Abuse.
Thom, B. (1984). Process approach to women's use of alcohol services. *British Journal of Addiction*. 79(4): 377-382.
Thompson, K. and Wilsnack, R. (1984). Drinking and Drinking problems among female adolescents: Patterns and influences. In: S.C. Wilsnack, and L. Beckman, (Eds.) *Alcohol Problems in Women: Antecedents, Consequences, and Intervention* (pp. 37-65). New York: Guilford Press.
Thornton, C., and Carter, J. (1988). Treating the Black female alcoholic: Clinical observations of Black therapists. *Journal of National Medical Association*, 80: 644-647.
Toneatto, A., Sobell, L.C., & Sobell, M.B. (1992). Gender issues in the treatment of abusers of alcohol, nicotine, and other drugs. *Journal of Substance Abuse*, 4: 209-218.
Trinh, C. (1998). The role of social support in the lives of pregnant women in recovery. In B.R. Sherman, with L.M. Sanders & C.Trinh (Eds.). *Addiction and Pregnancy: Empowering Recovery through Peer Counseling* (pp. 107-191). Westport, CT: Praeger Publishers.

Underhill, B.L. (1986). Issues Relevant to Aftercare Programs for Women. *Alcohol Health and Research World*, 11(1): 46-47, 73.

U.S. Department of Health and Human Services, Children's Bureau (1996). *Third National Incidence Study of Child Abuse and Neglect*. Washington, D.C.: U.S. Government Printing Office.

U.S. Department of Health and Human Services (1999). *A Report to Congress on Substance Abuse and Child Protection.* Washington, D.C.: Government Printing Office.

Uziel-Miller, N. & Lyons, J.S. (2000). Specialized substance abuse treatment for women and their children: An analysis of program design. *Journal of Substance Abuse Treatment*, 19: 355-367.

Rachel, V. (1985). *Woman like you: Life stories of women recovering from alcoholism and addiction*. New York, New York: Harper and Row Publishers, (223 p.)

Van Den Bergh, N. (1991). Having bitten the apple: A feminist perspective on addictions. In N. Van Den Bergh (Ed.), *Feminist perspectives on addictions.* New York: Springer Publishing Co.

Van Den Bergh, N. (1991). A feminist perspective on addictions. *Alcohol & Recovery*. July/August.

Vannicelli, M. (1984). Barriers to Treatment of Alcohol. *Actions/Misuse*, 5(1): 29-37. Belmont, MD: Appleton Treatment Center, Outpatient Service.

Vannicelli, M. (1986). Treatment considerations. In: *Women and alcohol: Health related issues*. Research Monograph No. 16. Washington, DC: U.S. Government Printing Office,(pp. 130-153).

Vannicelli, M., Nash, L. (1984). Effect of sex bias on women's studies in alcoholism. *Alcoholism: Clinical and Experimental Research*, 8: 334-336.

Volpe, J., & Hamilton, G. (1982-1983). How women recover: Experience and research observations. *Alcohol Health and Research World*, 7(2): 28-39.

Vourakis, C. (1989). *The Process of Recovery for Women in Alcoholics Anonymous: Seeking Groups Like Me.@* Ph.D. Dissertation, San Francisco: University of California.

Walitzer, K.S. & Dearing, R.L. (2006). Gender differences in alcohol and substance use relapse. Clinical Psychology Review, 26, 128-148.

Wallen, J. (1992). A comparison of male and female clients in substance abuse treatment. *Journal of Substance Abuse Treatment*, 9: 243-248.

Watson, R.R. (1994). *Addictive Behaviors in Women.* Totowa, NJ: Humana Press.

Webber, R. (1991). Cocaine dependence and compulsive sexuality. *American Journal of Preventive Psychiatry and Neurology*, 3(1): 50-53.

Wechsberg, W.M. & Cavanaugh, E.R. (1998). Differences found between women injectors in and out of treatment: Implications for interventions. In:. S.J. Stevens and H.K. Wexler (Eds.) *Women and Substance Abuse: Gender Transparency*, pp. 63-79; and *Drugs & Society*, 13(1/2): 63-79.

Wechsberg, W.M., Craddock, S.G., & Hubbard, R.L. (1998). How are women who enter substance abuse treatment different than men?: A gender comparison from the Drug Abuse Treatment Outcome Study (DATOS). In:. S.J. Stevens and H.K. Wexler (Eds.) *Women and Substance Abuse: Gender Transparency*, pp. 63-79; and *Drugs & Society*, 13(2): 97-115.

Wechsberg, W.M. (1995). Strategies for working with female substance abuse clients. In B. Brown (Ed.), *Substance abuse treatment in the era of AIDS* (pp. 119-152). Rockville, MD: Center for Substance Abuse Treatment.

Wechsberg, W.M., Craddock, S.G., & Hubbard, R.L. (1994). *Preliminary findings: Gender differences among those entering methadone treatment.* Presented at the National Methadone Conference, Washington, DC, April 21.

Weisner, C. & Schmidt, L. (1992). Gender disparities in treatment for alcohol problems. *Journal of the American Medical Association, 268*(14): 1872-1876.

Welez, M., Svikis, D., Jansson, L.M., Haug, N., Wells, K., & Golden, A. (1996). Parenting knowledge among drug-abusing women. In L.S. Harris (Ed.), *Problems of drug dependence, 1995: proceedings of the 57th annual scientific meeting. NIDA Research Monograph* (Vol. 161). Rockville, MD: National Institute on Drug Abuse.

Weisner, C. and Schmidt, L. (1992). Gender disparities in treatment for alcohol problems. *Journal of the American Medical Association,* 268(14): 1872-1876.

Wells, K.D. (1986). Recovering Black Female Alcohol Abusers' Perceptions Regarding the Contribution of Selected Factors in the Maintenance of Their Sobriety. Rutgers University – The State University of New Jersey, New Brunswick. *Dissertation Abstracts International*, 47(4): 1750-B.

White, W. (1998). *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Bloomington, IL: Chestnut Health Systems.

White, W. (1990). *PROJECT SAFE Program Manual.* Chicago, IL: Illinois Department of Children & Family Services.

White, W. and Chaney, R. (1993). *Metaphors of Transformation: Feminine and Masculine.* Bloomington, IL: A Lighthouse Institute Monograph.

White, W., Woll, P. and Godley, S. (1997). *The Delivery and Supervision of Outreach Services to Women*. Chicago, IL: Illinois Department of Alcoholism and Substance Abuse.

White, W. & Gasperin, D. (2006). *Addiction Treatment and Recovery: A Primer for Criminal Justice Personnel*. Springfield, IL. University of Illinois-Springfield Center for Legal and Policy Studies.

White, W. & Gasperin, D. (2006) *Recognizing, Managing and Containing the "Hard Core Drinking Driver."* Springfield, IL: Administrative Office of the Illinois Courts / Center for Legal Studies, University of Illinois Springfield.

White, W. & Kilbourne, J. (2006). American women and addiction: A cultural double bind. *Counselor*, 7(3), 46-51.

White, W., Woll, P and Webber, R. (2003) *Project SAFE: Best Practices Resource Manual*. Chicago, IL: Illinois Department of Human Service, Office of Alcoholism and Substance Abuse.

Widom, C.S. (1989). *The intergenerational transmission of violence.* New York: Harry Frank Guggenheim Foundation.

Wiebel, W. (1990). Identifying and gaining access to hidden populations. The collection and interpretation of data from hidden populations. *NIDA Research Monograph #98.* Rockville, MD: National Institute on Drug Abuse.

Willet, W.C. et al.(1987). Moderate alcohol consumption and risk of breast cancer. *New England Journal of Medicine*, 316: 1174-1180.

Williams, C.N. (1982). Differences in child care practices among families with alcoholic fathers, alcoholic mothers, and two alcoholic parents. Unpublished doctoral dissertation, The Florence Heller Graduate School, Brandeis University.

Williams, C.N. (1987). Childcare practices in alcoholic families: Findings from a neighborhood detoxification program. *Alcohol Health & Research World*, 11(4): 74-77, 94.

Williams, R., Saunders, J.B. (1983). Genetics of alcoholism: Is there an inherited susceptibility to alcohol-related problems? *Alcohol and Alcoholism*, 18(3): 189-217,

Williams, R.R., Horm, J.W. (1977). Association of cancer sites with tobacco and alcohol consumption and socioeconomic status of patients: Interview study from the third National Cancer Survey. *Journal of the National Cancer Institute*, 58: 525-547.

Wilsnack, S.C. (1991). Barriers to treatment for alcoholic women. *Addiction & Recovery,* (July/August).

Wilsnack, S.C., Klassen, A.D., Schur, B.E., et al. (1991). Predicting onset and chronicity of women=s problem drinking: A five year longitudinal analysis. *American Journal on Public Health*, 81: 305-317.

Wilsnack, S. and Beckan, L., (Eds.) (1984). Alcohol Problems in Women. New York: The Guilford Press.

Wilsnack, R.W., Wilsnack, S.C., Klassen, A.D. (1987). Antecedents and consequences of drinking and drinking problems in women: Patterns from a U.S. national survey. In: P.C. Rivers, (Ed.), *Alcohol and Addictive Behavior*, Lincoln, NE: University of Nebraska Press, (pp. 85-158).

Wilsnack, S. (1989). Women at high risk for alcohol abuse. *The Counselor,* 20: 16-17.

Wilsnack, S.C. (1976). The impact of sex roles on women's alcohol use and abuse. In M. Greenblatt & M.A. Schuckit (Eds.), *Alcoholism Problems in Women and Children*. New York: Grune & Stratton.

Wilsnack, S.C., Wilsnack, R.W., Klassen, A.D. (1986). Epidemiological research on women's drinking, 1978-1984. In: Women and Alcohol: Health Related Issues. Proceedings of a Conference, May 23-24, 1984. NIAAA Research Monograph No. 16, Rockville, MD: National Institute on Alcohol Abuse and Alcoholism, (pp. 1- 68).

Wilsnack, S. C. (1973) Sex role identity in female alcoholism. *Journal of Abnormal Psychology,* 82(2): 253-261.

Widom, C.S. (1989). *The intergenerational transmission of violence*. New York: Harry Frank Guggenheim Foundation.

Wolfe, D. A., Zak, L., Wilson, S., and Jaffe, P. (1986). Child witnesses to violence between parents: Critical issues in behavioral and social adjustment. *Journal of Abnormal Child Psychology*, 14: 95-104.

Women Alcoholics Have a Tougher Fight. (1945, May). *AA Grapevine*, 1(12): 3.

Women and Alcohol: Health Related Issues. (1986). Proceedings of a Conference, May 23-24, 1984. NIAAA Research Monograph No. 16, Rockville, MD: National Institute on Alcohol Abuse and Alcoholism.

Women in AA face special problems. (1946, Oct). *AA Grapevine,* 3(5): 1,6.

Women As a Special Population: Issues in Substance Abuse Programs. (1982). Bangor, Maine: Eastern Regional Council on Alcohol and Drug Abuse.

Woodhouse, L.D. (1990). An exploratory study of the use of life history methods to determine treatment needs for female substance abusers. *Response*, 13(3): 12-15.

Young, N. (1997b). Effects of alcohol and other drugs on children. *Journal of Psychoactive Drugs*, 29(1): 23-42.

Young, N., Gardner, S & Dennis, K (1998). *Responding to alcohol and other drug problems in child welfare: Weaving together policy and practice.* Washington, D.C.: CWLA Press.

Zankowski, G.L. (1987). Responsive programming: Meeting the needs of chemically dependent women. *Alcoholism Treatment Quarterly,* 4(4).

Zubretsky, T.M. & Digirolamo, K.M. (1996). The false connection between domestic violence and alcohol. In: A.R. Roberts, (Ed.), *Helping Battered Women*. New York: Oxford University Press.

Zuckerman, B., & Frank, D.A. (1992). "Crack kids": Not broken. *Pediatrics,* 89: 337-339.

Zuckerman, B, et al. (1989). Effects of Maternal Marijuana and Cocaine Use on Fetal Growth. *New England Journal of Medicine*, 320: 762-768.

Zweben, J.E. (1996). Psychiatric problems among alcohol and other drug dependent women. *Journal of Psychoactive Drugs*, 28(4): 345-354.

Appendices

Project SAFE
A Developmental Model of Recovery

By William White, in collaboration with Maya Hennessey,
Deborah Oberg and Diane Sonneville
(1990, edited by W.W. 2002)

Early Project SAFE reports raised a number of theoretical questions about the nature of addiction and recovery in women, and called for the construction of a research-grounded developmental model of recovery that could illuminate the styles and processes of addiction recovery among Project SAFE clients. In the absence of quantitative research data, stories and perceptions about stages in the recovery process for SAFE women were solicited from child welfare workers, outreach workers and treatment staff at all of the SAFE sites. This qualitative data was then organized into a beginning conceptualization of the stages of change experienced by most women involved in this project. This brief paper represents an attempt to provide a theoretical framework from which the recovery of Project SAFE women can be understood and from which interventions can be strategically selected and appropriately timed.

Recovery as a Developmental Process

There are a number of key propositions central to a developmental model of addiction recovery. Those most crucial to organizing the experience of women in Project SAFE include the following:

- Addiction recovery, like the active process of addiction, is often characterized by predictable stages and milestones.
- The movement through the stages of recovery is a time-dependent process.
- Within each stage of recovery are developmental tasks, skills to be mastered, certain perspectives to be developed, certain issues to be addressed, before movement to the next stage can occur.
- The nature of the developmental stages of recovery are shaped by the characteristics of the individual; the nature, intensity and duration of drug use; and the social milieu within which recovery occurs.
- Developmental stages of recovery, while highly similar within subpopulations of addicts, may differ widely from subpopulation to subpopulation.
- Treatment interventions must be strategically selected to resolve key issues and achieve mastery over key developmental tasks inherent within each individual's current stage of recovery.
- Treatment interventions appropriate to one stage of recovery may be ineffective or pose iatrogenic risks when utilized in another stage of recovery.

These propositions are consistent with the growing body of research on stages of change (Prochaska, DiClimente & Norcross, 1992).

What follows is not a developmental model of recovery for women. The proposal of such a model would imply that women experiencing substance use disorders present with gender-defined and gender-shared problems that are unaltered by other dimensions of individual character and experience. Such a model would also imply that there is a shared developmental trajectory (a singular pathway) of recovery for all women and that there exists a narrowly proscribed treatment technology to provide guidance through this developmental process. What follows is a developmental model of recovery for *persons* who share certain experiences and characteristics. There are many women for whom this model would not apply and many men for whom it would. The fact that more women than men share the core characteristics defined below is a function not of gender biology but of the social, economic and political oppression within which women are born and within which they must seek their individual destinies.

The Core of Shared Experiences and Adaptations

The developmental trajectory of addiction recovery is shaped by the totality of experiences each person brings to the recovery process and, in particular, what each person brings by way of Arecovery capital.@ Recovery capital is the total amount of internal and external resources a person can bring to bear on the initiation and maintenance of recovery (Granfield and Cloud, 1999). Populations for who share similar levels of recovery capital, similar assets and life experiences and circumstances, often share similar developmental processes of recovery.

Project SAFE women were often involved in a complex web of interlocking relationships (and problems) spanning several generations. The women who entered Project SAFE shared many experiences that shaped their perceptions of self, the self-drug relationship and the self-world relationship. It is impossible to understand the nature of addiction and recovery in these women without understanding the core experiences of their lives. Such core experiences include:

- Early and continuing losses
- Parental addiction and/or psychiatric illness
- Physical/sexual trauma
- Predatory social environments
- Recapitulation of family trauma in adult intimate relationships

When clinicians within Project SAFE compared the experience of SAFE women with the non-addicted women they had counseled who had not been involved in the abuse or neglect of their children, significant differences emerged. While women from both groups reported experiencing sexual abuse in childhood, the women of Project SAFE women reported an earlier age of onset of sexual abuse, multiple rather than single perpetrators of abuse, long duration of abuse (often measured in years), the presence or threat of physical violence as a dimension of the abuse, more boundary invasive forms of sexual abuse, and either being blamed or not believed when they broke silence about the abuse. What distinguishes Project SAFE women is not the

occurrence of physical or sexual abuse or early childhood losses in their lives, events that many women experience, but the intensity and duration of these experiences.

Project SAFE clients tended to share both certain conditions and events in their lives and certain meanings attached to these experiences. The experiences catalogued above created shared beliefs about themselves and the outside world. These beliefs became mottos for living and a major barrier to recovery:

- I am unlovable; I am bad.
- There is no physical or psychological safety.
- If I get close to people, they will die or leave me.
- My body does not belong to me.
- I am not worthy of recovery.
- Everybody's on the make; no one can be trusted.

Dependency as the Core Developmental Dimension for SAFE Women

In clinical staffings of Project SAFE women, the words Adependency, passivity, learned helplessness and learned hopelessness@ were frequent refrains. It is our belief that shifts in this dependency dimension mark the essence of the developmental process of recovery for SAFE women.

In America, there is a deep paradox related to dependency. The culture highly values self-reliance and autonomy, but prescribes roles to women which inhibit self-assertion and encourage service and sacrifice to others. Women who most inculcate those values ascribed to women are branded as Apathologically dependent.@ Women who challenge these values through self-assertion are often accused of somehow hurting their men, their children, their communities and their society. While most women experience some aspects of this cultural double-bind, some experience an intensified version of this self-dwarfing process. For the majority of women in Project SAFE, family of origin experiences began what became an escalating pattern of self-diminishing dependency upon people and things outside the self. Such patterns involve:

- An inability to state one's own wishes, needs, or ideas due to fear of conflict or rejection.
- A diminished capacity to define or assert one's own values and beliefs (to be self-directed).
- A severely diminished experience of self-legitimacy and self-value.
- An inability to pursue self-fulfilling, self-nurturing activities without fear and guilt.
- Achievement of esteem through identification with a person, group, or institution.
- A fear that life success or self accomplishment will be followed by punishment or abandonment.
- An inability to initiate action to resolve one's own problems.
- A programmed preference for passivity, withdrawal and helplessness when confronted by problems and challenges.

We do not view such dependency patterns as inherent in the biology or character of women. We view such patterns as flowing from self-obliterating family and cultural systems.

They are survival adaptations. They are strategies of self-protection. They are defenses against physical and psychological assault. Self-defeating patterns of dependency are highly adaptive, and passivity can serve as an alternative protective device to challenging and confronting family or cultural rules. Passivity and dependence often serve as homeostatic mechanisms within a marital/family system. Ego-sacrificing acts of women often serve to boost the egos of others.

This dependency dimension influences the manner in which these women must be engaged in the change process. Interventions, such as traditional confrontation approaches that heighten guilt and inadequacy, are misguided and harmful for this population. The dependency dimension influences the changing role of the treatment program staff in the long-term recovery process. In the developmental stages outlined below, we have charted a progression from self-defeating dependence to healthy inter-dependence. The desirable and achievable goal of the change process extols not autonomy and self-reliance, but reciprocity and mutuality. This process is depicted as a movement from the denial and abuse of self to an affirmation of self within the context of mutually respectful intimate, family, and social relationships.

The Limitations of Stage Theory

In 1969, Elizabeth Kubler-Ross published her now classic work *On Death and Dying* in which she described five stages of grief and mourning (denial, anger, bargaining, depression and acceptance). Many counselors have for years used this theoretical framework to assist them in working with grieving clients. Used appropriately, this theoretical model has helped many clinicians both understand and mediate the healing process involved in traumatic loss. Applied to restrictively, this theoretical model has been misapplied by some clinicians to program the grief experience of clients for whom alternative styles of healing may be more naturally appropriate. Similarly, stages of change theories have been very popular in the addiction treatment field in recent years. But we have also used such models used to exclude clients (defining Apre-contemplative@ clients as inappropriate for admission to treatment) rather than to enhance their readiness for change.

Models, as metaphors of collective experience, can be tools of empowerment for both clinicians and clients, particularly when the model fully embraces the experiences and needs of both. When a model doesn't fit the experience and needs of the client, its application can result in unsuccessful treatment or harmful treatment.

The construction of a developmental model of recovery for women in Project SAFE is an important milestone in the evolution of this project. It provides the theoretical foundation for what works and doesn't work in our interventions with these women and their families. It provides the framework that vindicates our movement outside the traditional boundaries of traditional theories and techniques to meet the needs of these women. The developmental model of recovery which follows should, however, not be viewed as a road map of recovery for all women, nor should the stages outlined be utilized as a prescriptive recipe whose ingredients and preparation procedures must always be the same. Our model is a road map that has utility only when it precisely reflects the clinical terrain within which we are working. When this terrain changes via core characteristics and experiences of women in Project SAFE, then the model should be adapted or discarded.

In our observation of and involvement with Project SAFE women over the past sixteen years, we have seen six identifiable stages in the movement from addiction to stable recovery. These stages and the roles helping professionals can play in each stage are described briefly

below. The stages are a composite of what we have seen with Project SAFE women. Some women skipped certain stages. Others varied the sequence. Still others went through several cycles of these stages during their SAFE tenure. The stages overlap and there are not always clear points of demarcation separating one from the other. For example, early stage issues of safety and trust don=t completely dissipate. They simply require less emotional effort as the ever-present roar of Adon't trust@ subsides to a whisper.

Stage 1: Toxic Dependencies

If there is any phrase that captures the pre-treatment status of Project SAFE women, it is Atoxic dependencies.@ They bring dependencies on alcohol, cocaine, heroin and other psychoactive drugs that have interfered with many areas of their lives. They exhibit a propensity to involve themselves in toxic, abusive relationships with men and women. They also exhibit a propensity to involve themselves in toxic relationships with Aenabling institutions@ whose effect is to sustain rather than break this larger pattern of dependency. The Project SAFE client has little sense of self outside these dependent relationships with chemicals, people and institutions.

The themes of death, loss, abandonment, and violation of trust in her life are constants that progressively diminish self-respect and self-esteem. Whether manipulated through nurturing or through violence, she has learned that the world is a predatory jungle in which physical and psychological safety is never assured. Out of self-protection, a secret self is created and encapsulated deep within this women. She protects and hides this self from exposure to outsiders. Her true self can never be rejected because it will never be revealed. Sealed in fear and anger, this secret self becomes so deeply hidden that the woman herself loses conscious awareness of its existence.

The locus of control during active addiction is increasingly of external origin. Her relationship with drugs cannot be internally controlled by acts of will or resolution. Her relationships with others are marked by inconsistency and unpredictability of contact. Everything in her life seems to be shaped by outside forces and persons. By the time a woman comes in contact with Project SAFE, the power to shape her own destiny has been obliterated by the chaos of her life. Her life is buffeted by the conflicting forces of her drugs, her drug using peers, her family, her intimate partner, and a growing number of social institutions closing in on her lifestyle.

Amidst this backdrop of chaos, she slides into increased passivity, increased hopelessness and helplessness and increased dependence on drugs and toxic relationships. There is pain in great abundance, but insufficient hope to fuel sustained self-assertion into recovery. APowerlessness@ for this woman is a fact of life, not a clinical breakthrough. The spark that can ignite the recovery process must come from without, not within. For social agencies to wait for this woman to Ahit bottom,@ in the belief that increased pain will motivate change is delusional and criminal. Where the internal locus of control has been destroyed, the client can Alive on the bottom,@ having lost everything short of her own life, and still not reach out for recovery. It is not a shortage of pain, but a shortage of hope and a lost capacity to act, that serve as the major obstacles to change. More potential sources of external control eventually emerge through crises related to homelessness, acute medical problems, arrest, victimization by violence, or through the abuse and/or neglect of her children.

Family of origin relationships are quite strained for SAFE women. Family members either share the client's lifestyle or have disengaged out of discomfort with the client's drug use

and lifestyle. And yet, family members may be pulled back in during episodes of crisis to take rescuing action on behalf of the client. The social worlds vary for SAFE women. Some are socially isolated, enmeshed in a solitary world of drug use surrounded only by a few primary relationships with active users or persons who support, via enabling, their continued drug use. Other SAFE women are deeply enmeshed in a culture of addiction, an exciting world of people, places and activities all of which reinforce sustained drug use. The drugs and the roles and relationships in the culture of addiction all hold out the promise of pleasure and power but alas, as a metaphor for her life, bring betrayal in the form of pain and loss.

The etiology of the neglectful/abusive behavior exhibited by the SAFE client toward her children springs from multiple sources: the emotional deficits and debilities resulting from her own family of origin experiences, the lack of appropriate parenting skills, environmental chaos that competes with parenting responsibilities, increased loss of control over the drug relationship, and sustained exposure to a predatory drug culture. She constitutes the ultimate paradox of motherhood. Scorned and shamed by those who don=t know her (AHow could a mother neglect her child because of a drug?@), her desire to remain the mother of her children will remain the primary external force that sustains her through the change process.

In short, the woman who will come in contact with Project SAFE is compulsively involved in dependent relationships with abusable substances and abusing people, lives in environments that are chaotic and traumatizing, and is constitutionally incapable of a self-initiated, spontaneous break in this dependent lifestyle. All of her experiences have confirmed that the world is a physically and psychologically dangerous place. Her contacts with helping professionals during this stage are likely to be marked by passive compliance (role playing) or by open disdain and distrust.

There is, however, as much strength in this profile as pathology. The ultimate pathology is the environmental pathology which demanded that SAFE women sacrifice their esteem and identity as an act of survival. While the consequences of these adaptations may appear as pathological personality traits to those unfamiliar with such traumatizing environments, seen from another perspective, these are stories of survival and incredible resiliency. The strength inherent in sheer survival is the seed from which the recovery process will eventually sprout. That seed must be acknowledged, nurtured and channeled into the change process.

Stage 2: Institutional Dependency

The initiation of sobriety and the period of early recovery for SAFE women is marked by decreasing dependence upon drugs and unhealthy relationships, and an increasing dependence upon Project SAFE staff and the institution within which it is nested. Stage 2 is marked by the following three phases: 1) testing and engagement, 2) stabilization, and 3) reparenting.

Rarely if ever do Project SAFE women present with a high level of motivation for change. The earliest stage of engagement is usually induced by external fiat (court mandated treatment or fear of losing children) or through the persistence of an outreach worker. Whether presenting with superficial compliance or open hostility, the engagement period is a ballet of approach-avoidance and ambivalence. The tipping of the scales are often shaped by the relative interactions of hope and pain. There is a hope-pain synergism (illustrated below) that dictates the outcome of our efforts at engagement.

The Hope-Pain Matrix

High Pain HP	Low Hope LH	HP-LH most typical initial pattern encountered with SAFE women. External control and hope-engendering relationships key ingredient to treatment engagement
High Hope HH	Low Pain LP	HH-LP represents honeymoon phase in drug relationship. Drug relationship experienced as solution rather than problem. Poor treatment success; high risk of relapse.
HP-HH produces high internal motivation and rapid engagement in treatment. Good treatment prognosis.	LH-LP represents post-honeymoon phase of drug relationship. Trust building by OR workers can set stage for treatment engagement during crisis.	

Where there is high pain and high hope, a rarity, engagement can be quick and intense. Where there is low pain and low hope, there is minimal chance of treatment initiation. It is in the combinations of high pain and low hope and high hope and low pain, that the intervention technology of outreach can work its magic of persistence and consistent positive regard to alter the equation to get treatment engagement. (See Chapter Six for a discussion of this technology.)

The earliest relationship between SAFE women and the treatment milieu is one of great ambivalence. Clients maintain a foot in both worlds (addiction and treatment) gingerly testing each step forward and backward. In this transition period can be found enormous incongruities and contradictions, e.g., clients who want to keep using drugs AND keep coming to treatment, clients who want staff to go away because staff make them feel good and hopeful. While this ambivalence may have its subtleties, it is most often played out behaviorally in dramatic fashion, e.g., missed days of treatment attendance, splitting in anger and then calling to seek reconciliation, relapse behavior, etc. True emotional engagement is rarely a bolt of lighting event. It is much more likely to be a slow process of engagement with every stage marked by testing behaviors.

The earliest experiences of positive regard and hope experienced by Project SAFE women can trigger strong counter reactions. The woman who too quickly reveals her secret self may react in anger (temper tantrums) or in flight (missed meetings). The hope-instilling positive regard from SAFE staff may escalate a client's self-defeating patterns of living, e.g., setting others up to reject her as a confirmation of her life positions that trust is foolish and nowhere is safe. When staff refuse to be driven back by these exaggerated defense structures, the client is forced to experience herself differently and to rethink her beliefs about herself and the world. This testing, experiencing acceptance and rethinking process may go on in its most intense forms for weeks before a woman fully commits herself to the SAFE program. For women who get through this initial stage, testing may resurface later during critical developmental milestones in

the recovery process. For women who cannot resolve this trust/safety issue, their drug using lifestyle will continue unabated.

In the stability phase, outreach and case management services provided through project SAFE have reduced the environmental chaos (housing, transportation, legal threats, etc.) to manageable levels and overall treatment efforts have created an initial (but still fragile) emotional bond between the client and the treatment team. As external threats to safety and survival subside, the Project SAFE client begins to master the personal and social etiquette of SAFE participation, e.g., regular attendance, group participation, etc. As soon as sobriety and environmental stability begins, emotional thawing and volatility escalates.

This can be a stage of raw catharsis. Pent-up experiences unleash powerful emotions when first aired to the outside world through storytelling. With the experience of safety, clients can begin peeling away and revealing layers of the secret self only to discover dimensions that were unknown even to themselves. Healing of this pain will occur in levels through all of the stages described in this model. At Stage 2, the most crucial dimension is the experience of acceptance by others following self-disclosure. There is, at this stage, a sense that shared pain is diminished pain, and that secrets exposed to the light of disclosure lose their power to haunt and control.

There are several dimensions of reparenting within Project SAFE spread over the developmental stages of recovery outlined here. At this early stage, Project SAFE takes over a parental role with project clients, tending to issues of survival and safety. It is a nurturing, Adoing for@ process. At an emotional level it involves experiencing unconditional Athereness@ -- the consistent physical and emotional presence of the program in the life of the client. It involves the experience of consistency, a non-voyeuristic and non-judgmental openness to their life stories, and the ability to tolerate testing, but still set limits. It is the experience that one can mess up, but not jeopardize one=s status as a family (SAFE) member. As clients become more receptive to this emotional nurturing, they may regress and become quite dependent upon the program. This escalating dependence should be seen not in terms of pathology, but in terms of a developmental process of healing. It is through this increased dependence, and the needs that are being met through it, that the client begins to fully disengage from active involvement in the culture of addiction. The program must now meet all those needs which the client formally met within the society of addicts. The program must be available to fully fill this vacuum at this stage if contact with the culture of addiction is to be broken. Does that mean that a stage of Adoing for@ the client, a stage of consciously cultivating client dependence upon the treatment institution, is clinically warranted? YES!

Key developmental tasks that must be mastered by the client during Stage 2 include:

- Resolving environmental obstacles to recovery.
- Working through the ability to maintain daily sobriety.
- Relationship building with staff that transcends stereotyped role behaviors of Aclient@ and Aprofessional helper@ (movement beyond compliance).
- Learning etiquette of program participation.
- Breaking contact and asserting isolation from culture of addiction.
- Exploring limits of safety in the treatment environment via storytelling and boundary testing.
- Accepting nurturing from project staff.
- Verbalizing, rather than acting out, compulsions of fight or flight.

During Stage 2, clients still have little sense of personal identity. Where identity in Stage 1 was formed through identification with a drug, a drug culture, and a small number of highly abusive relationships; identity in Stage 2 comes through drug abstinence, identification with a treatment culture, and a small number of highly nurturing relationships. Denial dissipates during Stage 2 and personalized talk about alcoholism/addiction reflects the growing recognition of Aaddict@ as an element of identity. Clients still need external sources of control over their behavior, although these sources begin shifting from negative (judicial coercion) to positive (regard for relationships with staff).

Clients who get stuck in Stage 2 (and programs which conceive of Stage 2 as the terminal stage of treatment) contribute to the growing population of chronically relapsing clients who, fail to function either in the culture of addiction or in the society at large, become institutionalized clients in the substance abuse treatment system.

Stage 2 begins the reconstruction of the relationships between the SAFE mother and her children. With the resolution of environmental chaos, the initiation of sobriety, and early engagement in treatment, the most dysfunctional aspects (neglect and abuse) of the parent-child relationship have been addressed, but it may be some time before quality parenting will appear. Early recovery parenting efforts often reflect a lack of basic parenting skills and efforts to compensate for guilt related to past drug-related deficiencies in parental effectiveness, e.g., overprotection or overindulgence. As the mother herself experiences reparenting in relationships with staff, she becomes more empowered to mirror these experiences with her children, e.g., feedback, nurturing, boundary setting, problem solving, etc.

Stage 3: Sisterhood

In Stage 3, relationships of mutual respect and trust established between the client and the Project SAFE staff begin to be extended to encompass other women clients in the SAFE project (one=s treatment peers). The earliest efforts in these peer to peer relationships are marked by diminished capacity for empathy, the inability to listen to another with the roar of one's own ego in check, the lack of social etiquette, and the need to clearly proscribe the limits of trust. Clients speak at the same time, fail to respond emphatically to painful self-disclosure, make commitments to each other that are broken, react to feedback with verbal attack or threats of violence or flight, etc. It is the treatment milieu that must provide the skill development and the relationship building processes to weld these disparate individuals into a mutually supportive group.

Over time, clients begin to extend their trust and dependence upon staff to a growing reliance on the help and support of their treatment peers. Within the structure of the treatment milieu, they move from the position of Anone can be trusted@ to a realistic checking of who can be trusted and the limits of that trust. The early friendships between treatment peers constitutes the embryo of what will later be a more fully developed culture of recovery. As skills increase, the client learns to not only speak, but to listen; to not only receive feedback, but to offer feedback; to not only receive support, but to give support. It is crucial that treatment staff provide permission and encouragement for decreased dependence upon staff and increased dependence on other health-enhancing relationships within and beyond the treatment milieu.

The peer milieu is an important vehicle through which Project SAFE women wrestle with some of their most troublesome treatment issues. This is the milieu within which sexual abuse and other family of origin pain is explored. It is here that they can grieve their many losses.

This is the arena within which abusive adult relationships are mutually confronted. This is the arena in which clients come together collectively to fight back against shame and stigma to restore their honor and self-respect both as women and as mothers.

During this stage, there is an intense exploration of victimization issues. Stories of victimization are shared. Catharsis of pain and anger is achieved. A Asisterhood of experience@ is achieved. Early identity reconstruction focuses on victimization issues. Individual and collective identity focuses heavily on what has been done to them. Projection is the dominant defense mechanism. The client sees herself in trouble due to persons, institutions and circumstances over which she has no control. It will be some time before this focus can shift to her responsibilities, her choices, her role in her current life position.

Key developmental tasks that must be mastered during Stage 3 include:

- Extension of self-disclosure to treatment staff to treatment peers.
- Early relationships with recovering role models encountered within the treatment site.
- Exploration of victimization issues.
- Rapid expansion of social skills (parallels period of early adolescent development).
- Treatment agency focused lifestyle develops as alternative to culture of addiction.
- Shift in relationships from drug-oriented to recovery-oriented.

Stage 3 is the first time SAFE clients begin to experience themselves as part of a broader community of recovering women. Identity and esteem are increasingly based on identification with this community. The shift in identity from Aaddict@ to Arecovering addict@ marks a beginning stage in the reclamation of the self. These shifts in identity are not without their risks as we shall see in the next Stage.

Major risks of relapse during Stage 3 come from panic, secondary to emotional self-disclosure, relationship problems between treatment peers, and failure to sever or reframe past drug-oriented intimate and social relationships.

Stage 4: Selfhood and Self-help

Where Stage 3 focused on shared experiences, SAFE clients in Stage 4 begin some differentiation from the treatment group. There is more focus on personal, as opposed to collective experience. The Avictim@ identity diminishes during this stage and there is a greater focus on self-responsibility. This stage involves an exploration and expiation of emotion surrounding one=s own Asins@ of commission or omission. Treatment time shifts from what Athey@ did to what AI@ did. There is a confessional quality to early work in this stage with, self-forgiveness being a critical milestone. There is, for the first time, a shift in focus from personal problems to personal aspirations. This stage marks the beginning reconstruction of self that will continue throughout the lifelong recovery process.

In Stage 4, Project SAFE women begin to experiment with the development of health-enhancing relationships outside the treatment milieu. Having developed some sense of safety and identity within the treatment milieu, they seek to extend this to the outside world by finding networks of long-term support. The two most frequent structures utilized by Project SAFE

clients for such support in Stage 4 are self-help groups and the church. This is a critical stage through which the emotional support the SAFE client has received from treatment staff and treatment peers is extended for the first time to a broader community beyond the treatment site. There is also a focus on rebuilding strained or ruptured family relationships during this period. With sustained sobriety and program involvement and obvious changes in her lifestyle, estranged family members once again open themselves to reinvolvement with SAFE clients.

Self continues to be defined in Stage 4 through external relationships. A period, perhaps even a sustained period, of extreme dependence upon this support structure, while criticized by persons not knowledgeable about the developmental stages of recovery, can be the critical stage in the movement towards long-term recovery. During this period, the client's whole social world may be shaped within the self-help or religious world. This period constitutes a period of decompression from the toxicity of the culture of addiction and a period of incubation within which the self and self-world relationship are reconstructed.

If the shift in dependence from the treatment milieu to outside supports is made too quickly, the client will experience this encouragement for outside relationships as abandonment by the treatment staff. Traditional short-term treatment models that encourage this shift at a very early stage in recovery may inadvertently recapitulate the client's fear and experience of loss and abandonment. In Project SAFE, we found that these relationships needed to supplement, rather than replace, those primary relationships of support within the treatment milieu.

There is a reassessment and decision point during Stages 3 and 4 as whether to move forward in the recovery process or to retreat back into the world of addiction. During these stages, the full implications of the recovery lifestyle become clear. There is fear that long term recovery is still not a possibility. There is fear of the future unknown and their ability to handle it. As bad as the past is, it continues to exert its seductive call as a world they know better than any other. If treatment contact and support is prematurely ended during this stage, relapse is likely.

Stage 5: Community Building

In Stage 5, SAFE women extend their system of supports into the broader community. It is at this stage that clients must figure out how to maintain sobriety while fully living in the world. It is a stage of lifestyle reconstruction. Friendships that are based neither on active addiction nor shared recovery are explored and developed. The earliest activities within this stage may begin very early or very late in the recovery process. For SAFE women, the earliest activities are often initiated via outreach workers. Tours of community institutions, getting a library card, going on picnics, bargain hunting at garage sales and flea markets, and experimenting with drug-free leisure may all be aspects of community building initiated through the treatment experience. A major aspect of Stage 5 is the establishment of drug free havens and drug free relationships that can nurture long-term recovery. Another aspect of this stage is the repositioning of the family in the community, re-establishing old healthy linkages to community institutions and building new linkages.

It is important that treatment staff possess a sensitivity to non-traditional pathways to recovery. Many recovering women may set the roots of their recovery in institutions other than traditional self-help groups. The church served as a primary support institution to many SAFE women, either as an adjunct or an alternative to traditional addiction self-help groups.

The parenting of SAFE mothers changes in a number of ways during these later stages of recovery. Earlier stages set the groundwork through the acquisition of basic parenting skills and working through stages of overindulgence and overprotection. The emotional needs of the mother are so intense early in the recovery process, that it is very difficult for her to maintain a sustained focus on the needs of her children. In Stage 5, however, the intensity of these internal needs have been addressed to allow for a much richer quality in the relationship between the client and her children. Where she achieved consistent physical presence in earlier stages of recovery, she now creates a consistent emotional presence in the life of her children.

There is also a shift in Stage 5 in the relative health of the client=s intimate relationships. Abusive relationships which may continue into the early stages of recovery have now been changed or severed. Some, at this stage, will have gone through experimentation with a variety of relationships, some will have found a primary long-term relationship, while others may find themselves content for the time being to seek their destiny without the security or burden of a primary relationship.

Stage 6: Interdependence

Stage 6 in the developmental progression of recovery for SAFE women, constituted not by a fixed point of achievement, but entry into a lifelong process of doubt, struggle, and growth. The shift from the earliest stages is one from self-negating dependence to self-affirming inter-dependence. This stage is marked by the emergence and continued evolution of an identity that transcends both the addictive history and the history of involvement with helping institutions. In a literal sense, this self-emergence is really not a Arecovery@ process, since recovery implies a recapturing or retrieval of something one once had. This is not retrieval of an old self; it is the creation of a new self. It is more a process of Abecoming@ than a process of Arecovering.@

Due to the lack of long term follow-up studies of Project SAFE, we don't know a lot about this stage of recovery for SAFE women. We do have inklings of some of the elements within this stage as more and more women stay in touch with the staff over a period of years. It seems to be marked by:

- Movement toward one=s personal aspirations, often reflected in achievement of some personal milestone, e.g., completing high school, getting into college, and gaining employment.
- Working through the tendency to substitute drugs with other excessive behaviors, e.g., workaholism, food, and sex.
- A maturing out of the narcissistic preoccupation with self that characterized active addiction and the early stage of recovery.
- The creation of a social network in which relationships are characterized by mutual respect and support.
- The organization of one=s life around a set of clearly defined values and beliefs.
- The emergence of acts of service to other people (including, for some, coming back years later to work as outreach workers in Project SAFE).

There is tremendous diversity in how women within Project SAFE have experienced, or failed to experience, the recovery process. For some, sobriety and the enhancement of parental functioning were introduced into an otherwise unchanged life. For others, Project SAFE would represent the beginning of a life-transforming recovery process. It is our hope that this paper has captured some of the shared experiences that transcend this diversity.