SUBSTANCE ABUSE AND WOMEN: A COMPREHENSIVE QUALITATIVE ANALYSIS OF THE LITERATURE

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ABSTRACT

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Substance use disorder is a collection of physiological, cognitive, and behavioral symptoms that appear when an individual continues to use a substance even though it is producing significant problems in the individual's life (American Psychiatric Association, 1994). Substance dependence is exhibited when a person uses a substance to produce a mood change but then begins to need the drug more often and in larger amounts to achieve the same effect. Until the 1970's, substance abuse was seen almost exclusively as a male problem (Baron-Faust, 1997). In the 1950's, it was estimated that there were five or six male substance abusers to every female substance abuser (Davis & DiNitto, 1998). Estimates in the 1990's indicate that this

ratio is now approximately three males to every one female (Davis & DiNitto, 1998). The Center for Substance

Abuse Treatment (1996) reports that 4.5 million women are alcohol abusers, 3.1 million women use illicit drugs on a regular basis, and 3.5 million women misuse prescription drugs.

The growing recognition that substance abuse is a seriously debilitating disorder for women has caused tremendous concern within the past 30 years. This concern has resulted in a dramatic increase in research surrounding the female substance user. Research indicates several differences between the male and female substance user, including the etiology of substance use and a differentiation of physical symptoms that result from the substance use. Results from etiology research indicates women may begin to abuse substances as a form of self medication for such disorders as depression, post traumatic stress disorder (PTSD), and or an eating disorder (Bernnardez, 1980; Gil-Rivas, Fiorentine, & Anglin, 1996; Young, 1990). Recent research has also studied and evaluated present treatment programs in a search for the most effective forms of treatment for female substance users.

In this comprehensive meta-analytic research study, substance abuse as it pertains to women is discussed in detail. A brief history of substance use and women will be presented plus a brief history of pharmacology research and its relevance to women will also be included. The risk factors for three other often diagnosed, coexisting mental disorders prevalent within the population of female substance user will be

discussed. This will be followed by a brief history of substance abuse treatment that is centered on the male model of a substance abuser. Information on alternatives to the male model treatments is included. The alternative treatment suggestions result in more positive treatment outcomes for the female population of substance abuser as the philosophy of "one size fits all" does not appear to address the needs of most women seeking treatment for alcohol and drug abuse.

This study will focus on the substance abuse of white women, but it would be irresponsible to conclude women of color, differing ethnic backgrounds, disabled, lesbian, and aging women do not have similar difficulties. While social influences such as poverty, violence, sexism, and related stress are part of many women's life experiences, the biopsychosocial consequences of special populations of substance abusing women are further complicated.

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Chapter I

Introduction

Volumes of literature exist on alcoholism and drug addiction. However, studies that include women substance abusers are a relatively recent area of interest in research. This current research is now indicating a collage of factors that differentiate female substance abusers from male substance abusers. As the collage is examined, a pattern of possible coexisting problems found in female substance abusers is emerging. These coexisting problems can be both the cause and the consequence of substance abuse.

It would be irresponsible to begin a discussion detailing the issues of women and substance abuse without first addressing cultural issues. It is fundamental to examine women's environment in context with women's mental health. "Stress, poverty, violence, powerlessness, ethnic, racial and sexual orientation all intercede in a woman's life experience," (Baron-Faust, p. 17, 1997). More women than men live in poverty (Hales & Hales, 1995). Over one-third of all single-parent households are headed by women living below the poverty line (Center for Substance Abuse Treatment, 1993). While women are the contributors to half of all family incomes, they often earn their contribution in low-wage and low-mobility jobs; women still earn less than 75 cents for a male-earned dollar (Migas, 1996). Women are also more likely to be the victims of violence.

A central issue for women substance abusers is a history of violence that surrounds her. This violence often includes a history of sexual trauma. Brady,

Guy, Poelstra, & Brokaw (1999) estimated one out of every three women have experienced childhood sexual abuse. Baron-Faust (1997) estimated that one in every four women will be the survivor of rape and that 20 to 30 per cent of women will be physically assaulted by a partner or ex-partner in the course of her lifetime. Several research studies show (Davis & DiNitto, 1998; Brady et al, 1999; Baron-Faust, 1997; Herman, 1992) the incident rate for violent trauma, including incest, battering, childhood sexual abuse, and sexual assault for women in alcohol and drug abuse (AODA) treatment ranges from 40 – 90 per cent. The results of this violent history may be manifold with high rates of comorbidity for specific mental disorders found in this population.

Studies (Baron-Faust, 1997) are showing a definite link between violence against women and mental disorders most diagnosed in women. "Sexual abuse and substance abuse frequently co-occur in women" (Davis & Wood, p. 123, 1999). A substantial portion of women diagnosed with a substance abuse disorder may also have post-traumatic stress disorder (PTSD), an eating disorder, and or depression. This study will examine the coexisting issues of female substance abusers. This will include the difficulties that arise in correctly diagnosing mental disorders that often coexist in substance abusing women.

This study will also focus on the traditional alcohol and drug abuse treatment programs as there is a growing concern that these traditional programs are not addressing the specific needs of women (Kasl, 1992; Glover, 1998). There is a growing concern that the traditional treatment programs may even be

contributing to women “entering a revolving door of poor treatment” (Irwin & Stoner, 1991). Repetitive relapse is often the unsatisfactory result. Treatment efforts must address the problem areas in addition to the drug use (Hser, Polinsky, Madione, & Anglin, 1999). “Evidence indicates that, if left untreated, these other life problems leave clients at high risk for relapse to drug use” (Nelson-Zpluko, Kauffman, & Dore, p.54, 1995). Use of the traditional disease model, or the 12-Step philosophy, with the focus on the addiction itself while not addressing the coexisting problems of women may even be detrimental.

Since its conception in the late 1930’s, Alcoholics Anonymous (AA) and its 12-Step program, designed and originated to meet the needs of white, middle-class male alcoholics, has dominated the recovery field (Kasl, 1992). Periodically there have been attempts to challenge AA and 12-Step approaches to recovery: Women For Sobriety (WFS), Save Our Selves (SOS), the Rational Recovery Movement, and the Sixteen-Step Empowerment Program for women and minorities. While these approaches have offered some alternatives to the recovering substance abuser, they have remained outside of the mainstream treatment programs with the 12-Step program the core of most alcohol and drug abuse treatment facilities (Kasl, 1992). Twelve-Step programs have also become the framework of most self-help groups that are recommended as support in recovery (Forth-Finegan, 1991).

AA and 12-Step programs have many proponents and opponents. Proponents believe that this program has literally saved their lives. The 12-Step belief system and AA slogans can become a recipe for healing (Kasl, 1992). For others, the

slogans and belief system are too rigid, too religious, insensitive, and dominating. Women and minorities have found that being in a group with white men replicates society's hierarchy: white men often dominate the group by talking the most, interrupting others, and are often insensitive to views and experiences other than their own (Kasl, 1992; Kandall, 1996; Hall, 1994). Treatment programs that include men are often difficult for women who have been victims of sexual abuse (Avé-Lallemant, 1997).

While AA and Twelve-Step programs are valuable resources, this study intends to suggest that not everyone will find them helpful and accepting. This study also intends to bring awareness to the treatment community regarding the limitations of traditional recovery groups, so that these programs do not encourage absolute compliance with the programs but support recovery with a flexible approach, and be willing to create recovery groups that are specialized for female populations. It would be an oversight to consider that the presenting problems that women substance abusers bring into alcohol and drug abuse treatment have been solved or eliminated solely by sobriety or abstinence from alcohol and/or drugs, therefore resulting in recovery. Recovery must include a balance of life skills that bring meaning and productivity to those receiving treatment for substance abuse.

In this comprehensive qualitative analysis of the literature, substance abuse as it pertains to women will be discussed in detail. Substance abuse will be described with an emphasis on the differentiation of female and male substance abusers followed by a brief history of substance abuse in women and a brief history of

pharmaceutical research and women. The comorbidity of other disorders often present in women substance abusers will be presented as will the difficulties in diagnoses when more

than one mental disorder is present. A history of substance abuse treatment will be explored followed by a synergistic approach of recommendations that will be useful in the designs of successful treatment programs for addicted women.

Statement of the Problem

Until recently, substance abuse was believed to be a disorder that affected mostly males. It was assumed that the numbers of women addicts was small and that those addicted women were deviant to both the male addict and particularly deviant to the proscribed gender roles of females. Treatment programs were designed and based on the male model of a substance abuser.

Now that it is known that substance abuse is prevalent among women, an increasing number of researchers are exploring the area of female substance abuse. This research is finding connections between substance abuse, violence, and certain mental disorders prevalent among women. Researchers are also discovering that traditional treatment programs designed by men for men need to be rethought and redesigned to be optimally effective for the female substance abuser. It is the
intention of this study to coalesce the research literature into a useable format to enable treatment providers to be better prepared in attending to issues surrounding women substance abusers.

Definition of Terms

Substance abuser, chemically dependent and addict are terms that are used interchangeably throughout this paper. The terms refer to a person using a substance to

produce a mood change that subsequently requires a drug or alcohol more often and in larger amounts to achieve the same affect. Eventually the person is unable to control the addiction, with dependency on a substance the result. This use continues, no matter what the consequences may be to themselves, their families, their finances, or their employment (Baron-Faust, 1997; Davis & DiNitto, 1998).

The acronym AODA, Alcohol and Drug Abuse, is another way of referring to the dependency which may be experienced while using substances.

Traditional treatment and Twelve-Step programs refer to the commonly accepted treatment modality of recovery based on the Twelve-Step treatment philosophy of Alcoholics Anonymous (see Appendix).

Methodology

For this thesis, the writer intends to complete a comprehensive qualitative analysis of the literature. This will require to drawing from a variety of resources.

The University of Wisconsin-Eau Claire Library Catalog and the University of Wisconsin-Stout Library Catalog were the resources of the initial step. This facilitated the search for books, periodical articles, periodical holdings, and theses. The *Library of Congress Subject Headings* was also utilized to find the standard subject heading which was used in both the Eau Claire and the Stout University catalogs. The inter-library loan programs at both universities allowed the researcher to access copies of journal articles and periodicals from a large collection of universities involved in the inter-library loan program that were unavailable at Eau Claire or Stout libraries.

The Internet and World Wide Web were also searched to locate current information on women and substance abuse. *The Index of Web Sites* facilitated the use of this technological resource.

Two electronic databases: Psychlit and ERIC were used to find journal articles. Psychlit is an electronic database that has provided summaries of literature in psychology and related fields since 1974. ERIC is an electronic database that summarizes literature in the field of education collected by the Educational Resources Information Center and published in the *Current Index to Periodicals in Education.*

Various national organizations that provide information about substance abuse and treatment were also contacted. Some of these resources included Women Reaching Women, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services plus non-traditional treatment organization such as Sharing

Treatment and Resources for Women (STAR) and the National Rural Institute on Alcohol and Drug Abuse (NRIADA).

Other excellent sources of information were found in the reference sections of books, periodicals, and journals. Guidance and references from respected authorities working in the field of alcohol and drug abuse treatment were also employed. An exhaustive review of all the above mentioned sources facilitated the culmination of this paper.

Researcher as Instrument

In a comprehensive qualitative analysis of the literature, the researcher is the instrument; framing questions, gathering specific information, making decisions, and analyzing information in a manner consistent with their own background and theoretical perspectives (Kazdin, 1998; Meloy, 1994). Qualitative researchers must therefore be attentive to subjective effects, and one way to address concerns about the influence of the researcher's own position is to make explicit their own views (Kazdin,1998; Meloy, 1994). What follows is an explanation of this researchers own orientation and research interest in this topic.

I am a nontraditional master's level student currently doing a practicum in the Counseling Services department at the University of Wisconsin-Eau Claire. My

master's degree work is in guidance and counseling with an emphasis in alcohol and drug abuse issues. I have been involved in nontraditional treatment programs for the past 10 years. My interest in nontraditional AODA treatment began with my own recovery and dissatisfaction with traditional 12-Step approaches to recovery.

From this personal perspective, I have an interest in finding approaches that are expansive, creative, and empowering. The goal of recovery is to create internal balance that will lead to a sense of inner peace, security, and growth. I found 12-Step programs did not provide a healing experience and was curious to explore the experiences of other women. To my delight, I found several alternative treatment ideas being developed.

Addiction impacts all areas of a person's life. Family life, work life, relationships with others, and with the self are effected by addiction. Addiction is an equal-opportunity disease, not discriminating between male or female. This comprehensive qualitative analysis of the literature is approached from my feminist perspective that examines and hopefully expands understanding of the way gender impacts addiction and treatment.

This analysis is an attempt to address the mainstream treatment programs by exploring women's issues in depth, both historically and currently. This research paper has attempted to ensure reliability and validity through the use of two criterion; conformability and triangulation. "Conformability refers to the extent to which an independent reviewer could conduct a formal audit and re-evaluation of the procedures and generate the same findings" (Kazdin, p. 254, 1998)

"Triangulation refers to the extent converging data from separate sources exist to support the conclusion" (Kazdin, p. 254, 1998). I believe conformability has been ensured through this paper's extensive list of references. An independent reviewer could re-evaluate the procedures and generate the same findings. The extent of the converging data from separate sources ensures triangulation. In a further attempt to ensure validity, including an exhaustive comprehensive analysis of themes and explanations, this paper has been

reviewed throughout the process of gathering and interpreting information by my thesis advisor, Dr. Charles Barnard, who has offered additional perspectives, insights, and advice.

Chapter III

Literature Review

In this comprehensive qualitative research study, substance abuse as it pertains to women is discussed in detail. A brief history of substance use and women will be presented plus a brief history of pharmacology research and its relevance to women will also be included. The risk factors for three other often diagnosed; coexisting mental disorders prevalent within the population of the female substance abuser will be discussed. This will be followed by a brief history of substance abuse treatment that is centered on the male model of a substance abuser. Information on alternatives to the male model treatments is included. The alternative treatment suggestions result in more positive treatment outcomes for the female population of substance abuser as the philosophy of "one size fits all" does not appear to address the needs of most women seeking treatment for alcohol and drug abuse.

Before the 1970's, drug addiction and alcoholism were viewed almost exclusively as problems of men (Davis& DiNitto, 1998). Before the 1970's, research studies overwhelmingly used male subjects when studying the etiology, physiological effect, psychological aspects, and characteristics of people abusing substances. The same male population was used when studying assessment instruments and the effectiveness of treatment modalities (Irwin & Stoner, 1991). In the thirty years since the early 70's and the beginning of the women's movement, there have been many social changes. Before the 1970's, women used to dream

about marrying a professional; now they dream about becoming a professional. Legislation that mandated affirmative action and barred gender discrimination was put into place and women previously denied access to education and professions that were dominated by males, moved into the work place and the universities (Spence & Hahn, 1997). A generation of scholars, social workers, mental health professionals and medical researchers have brought enlightenment to the needs of women, including those women suffering from drug and alcohol addictions.

Throughout the 70's and 80's, feminists were busy striving for equality with men; most were extremely leery of admitting there were differences between men and women, aside from the visibly obvious (Ehrenreich, 1999). Equality appeared to demand sameness because gender differences have historically resulted in the lower social status of women with much of what has been deemed female viewed as less desirable, less powerful, and less healthy (Bernandez, 1980).

Mental and Physical Definitions for Genders

Researchers studying the standard of mental health for women and men found that clinicians actually held different ideals for a healthy, fully functioning adult male than for a healthy, fully functioning adult female.

> The ideal healthy woman was described as being more submissive, less independent and adventurous, more easily influenced, less aggressive, and competitive, more easily excitable in minor crisis, more easily hurt, more emotional, more vain about her appearance, less objective, and less interested in math and science than the ideal healthy man. Also, the clinician's ideal of the

> healthy man was similar to that of a healthy, mature adult (gender unspecified), but their ideal of a healthy woman was quite different than both. It appeared, then, that women were caught in a double bind. If they met the mental health standards for their own gender, they automatically fell short for the general adult population. If they met the standards for a healthy adult, they were automatically defined as unfeminine and thus poorly adjusted (Lips, p.257-258, 1993).

The different ideals for mentally healthy males and mentally healthy females have contributed to not only the facilitation of addictions in the female population but they have also have contributed to keeping the addiction hidden or denied by both the addicted women and society.

That women have historically been viewed as less physically and less mentally healthy than men has made women vulnerable to a variety of treatments. Many of the treatments have included the use of different drugs. "Throughout recent history women have been thought to need special protection and regarded as less able to bear pain and psychic discomfort" (Kandall, p. 8, 1996). Women have been medicated, or have self-medicated for centuries because of this attitude by physicians and by society,

Brief History of Women and Substance Use

For obvious reasons, this paper cannot attempt an entire history of women and drug use that covers centuries. This paper will focus on the past one and one-half centuries, beginning with patent medicines. By the end of the 19th century,

unregulated patent medicines were easily accessible (Kandall, 1996). These tonics contained alcohol or opiates or a combination of the two. Testimonials to their effectiveness for treating a variety of ailments, ranging from sexual exhaustion, deficient mental control, headaches, chills and timidity to insomnia and indigestion, were published in many of the women's magazines (Ehrenreich & English, 1978). These ailments were often the symptoms of 'neurasthenia' or nervous weakness. Since women were considered less mentally and physically healthy than men, physicians and pharmacists prescribed and dispensed patent medications most often to the female population. "The female predominance among the addicted population is largely the result of Victorian medical practices" (Kandall, p.23, 1996). Self-medication by women who believed in their gender stereotype and the cures promised by advertisements aimed directly at the stereotypical woman plus the easy accessibility of patent medicines also shares in the responsibility for the disproportionate numbers of female addicts. "Through advertisements and endorsements, the pharmaceutical industry encouraged women to turn to drugs to ease their minds and bodies" (Kandall, p. 41, 1996). Regardless of the prevalence of drug addiction among women, addiction was seen as a man's disease.

As the 19th century was coming to a close, physicians and society were becoming aware of the dangers of addiction. During the first half of the 20th century, efforts to educate physicians concerning the dangers of addiction plus legislation making narcotics (opiates, cocaine, and marijuana) illegal except by prescription made the previous easy access to narcotics more difficult. The federal

government assumed control, arresting and penalizing persons in violation of the Harrison Anti-Narcotic Act of 1914 (Kandall, 1996)). The prices for the now-illegal narcotics soared. Physicians and pharmacists began prescribing opiates less often and the number of female addicts began to decrease. While quantitative data is extremely limited at best, it was estimated that the majority of opium users before legislation were women and that number dropped to less than 29 per cent of the addicted population by the 1930's (Fillmore, 1984, Goldberg, 1995; Kandall, 1996; Ehrenreich & English, 1978).

As a result of criminalization, the stigmatization for drug possession and drug use increased, particularly for women. The federal efforts to regulate substance use appeared to divide the female addict into two classes. The well-off female user could afford to continue to receive drugs from private physicians and avoid the social retributions of an addict in the new anti-drug atmosphere of the United States. She could also afford to pay for the limited treatment that was available during this period. On the opposite end, the emphasis on punishing addicts, not only kept the poor and disadvantaged female user without treatment, she was often imprisoned for committing petty crimes or prostitution to support her now illegal substance use (Gordon, 1981).

During this same time period of 1910-1930, concern about the use of alcohol and the problems that it caused was also gaining the interest of society (Kasl, 1992). This concern was centered on male alcohol abuse while concern about alcohol problems among women was almost nonexistent. But when women did use

alcohol, once again they were subjected to a different standard than the male alcohol user with women perceived as more deviant than the male drinker (Davis & Di Nitto, 1998). "Stepping out of the feminine role was seen to be more abnormal, more pathological and associated with other deviant statuses (prostitution and promiscuity)…." (Fillmore, 1984).

In part, the different standards for male and female mental health can be attributed to their different gender roles in society. The traditional gender role for women include nurturer and caretaker and that she be unassertive and less independent. This gender stereotype has placed women in a second class status in society and consequently women are more vulnerable to oppression. "Oppression is defined as systematic harm that people with power do to people with less power" (Goldberg, p. 791, 1995). Oppression can take many forms.

Discrimination in employment, wages, and promotion opportunities leads to limited access to positions of power, status, and economic security (Goldberg, 1995). "Women in the United States experience much higher rates of poverty than men, and female-headed households constitute the largest percentage of impoverished families" (Neslon-Zpluko, Kauffman, & Dore, p.48, 1995). Women are more vulnerable to physical abuse, sexual abuse, and sexual harassment (Davis & DiNitto, 1998; Slalavitz, 1999). The result of the oppression is pain, alienation, low self-esteem, and higher levels of anxiety and depression (Goldberg, 1995; Nelson-Zpluko, et. al, 1995; Davis & DiNitto, 1998; Kasl, 1992).

Historically women have not had the resources to alter the unfavorable conditions in their lives that are the result of their second class status and oppression. And historically many women have attempted to cope with their oppressive conditions through medication, both licit and illicit. As stated earlier in this paper, there is widespread consensus that women were the predominant users of unregulated patent medicines previous to the Harrison Act of 1914 which attempted to regulate narcotic use (Goldberg, 1995; Kandall, 1996). Research also suggests (Davis & DiNitto, 1998; Goldberg, 1995; Kasl, 1992; Kandall, 1996; Nelson-Zpluko et. al, 1995; Baron-Faust, 1997) that the inclination of women to self-medicate is an attempt to cope with oppression. The inclination for women to self-medicate was facilitated by the double standard for mentally and physically healthy males and mentally and physically healthy females. Indeed, an entire branch of the American pharmaceutical industry owes its growth to the common belief that women required medication to supplement their deficient health (Kandall, 1996).

Post World War II History of the Pharmaceutical Research and Industry

The 1950's brought the discovery of prescribed tranquilizers and stimulants. Once again magazines touted the miracles of pills, and women were encouraged to use them for appetite suppression, depression, nervousness, and to increase general happiness (Kandall, 1996; Ehrenreich & English, 1978). "Drug advertisements perpetuated society's prejudices about women, who were almost always portrayed unfavorably as weaker, as less able to cope, as helpless" (Kandall, p. 169, 1996). Women continued to be victims of stereotyping.

The stereotyping followed women into the physician's office where women in the 1950's and the 1960's received 60 percent of all prescriptions for tranquilizers and stimulants (Kandall, 1996; Goldberg, 1995). This percentage has risen in the 1990's with women receiving 70 percent of all prescriptions written for psychotropic drugs (e.g.: tranquilizers, sedatives, stimulants, and painkillers) writes Rita Baron-Faust (1997).

The advantages of psychotropic medications cannot be dismissed. Before their discovery in the 1950's, crippling mental illnesses hospitalized and institutionalized its victims for years. The correct medication has made it possible for many people with mental disorders to live productive, satisfied lives (Baron-Faust, 1997). However, until recently, women have been excluded from the major psychotropic drug trials (Baron-Faust, 1997; Hales, 1997). Once again the discrepancy between physically healthy males and females must be considered.

Over half of visits to physicians result in prescriptions (Hamilton & Jensvold, 1995). "Over half of the drugs prescribed today have never been tested on women" (Hales, p, 54, 1997) and women have been explicitly excluded from drug trials (Hamilton & Jensvold, 1995). Since the 1970's there has been increasing concern about generalizing medication doses from exclusively or predominantly male samples to females (Hamilton & Jensvold, 1995; Baron-Faust, 1997; Hales & Hales, (1995). It wasn't until 1993, when the Food and Drug Administration (FDA) stated that they would "…end the ban on women's participation in most drug safety tests and require companies to carry out analysis by sex in virtually all applications

for new drugs" (Hamilton & Jensvold, p.10, 1995). Drugs act differently in women for many reasons.

"Because of variations in men's and women's body size, liver function, metabolism, and the rate at which they absorb medication, there can be tremendous gender differences in how drugs affect women" (Hale, p. 54, 1997). Estrogen levels affect digestion, especially during the premenstrual period. "Five to ten percent of women can have significant changes in drug metabolism premenstrually" (Baron-Faust, p. 278, 1997). Because of these differences, women may need higher or lower doses of medications (Hamilton & Jensvold, 1995). "It is known that women have more side effects and twice as many fatal drug reactions to psychotropic drugs as men do" (Baron-Faust, p. 272, 1997). As previously discussed in this paper, women receive 70 percent of all prescriptions written for psychotropic drugs. Also, previously discussed, historically women have attempted to cope with oppressive conditions through medication, both licit and illicit

But while the prescribing practices of medicating women with tranquilizers, sedatives, stimulants, and painkillers and the practice of self-medication by women may alleviate some of the symptoms, drugs do not provide cures for unfavorable, oppressive conditions. "Unfortunately, drug use provides only temporary respite and eventually exacerbates rather than ameliorates problems resulting from inequitable conditions for women" (Nelson-Zpluko, et. al. 1995). A crucial question to ask at this point is when and why are drugs prescribed for women?

Sedatives and minor tranquilizers are most often prescribed to women who test positive on the alcohol portion of the Diagnostic Interview Schedule (Amodei, Williams, Seale, & Alvonado, 1996). "Minor tranquilizers are often prescribed erroneously for undiagnosed depression" (Bernandez, p. 23, 1980). Medication inaccurately prescribed can complicate the treatment of depression (McGrath, et. al., 1990). Women suffering from PTSD often are diagnosed with depression and treated with an anti-depressant, disguising the PTSD and leaving it untreated (Young, 1990). Alcoholic women are more likely to present for treatment with histories of abusing other substances and more frequent use of sedatives and tranquilizers (Amodei, et. al., 1996). This correlates with research findings that women are less likely to be questioned about alcohol use but are more often prescribed medication (Amodei, et. al., 1996). Researchers (Nelson-Zpluko, et. al., 1995; Hamilton & Jensvold, 1995; Bernandez, 1980; Mowbray, 1995) suggest that the use of pharmacological treatment may reinforce the woman's impression that something is wrong with her, may obscure a solution to the underlying problem, and promote a passive stance in women, silencing women from rightful complaints.

In summary, research cited in this paper indicates that women have historically been stereotyped as less mentally and physically healthy than men. This has placed women in a second class status to men and has led to historical oppression of women. Women have, also historically, been the disproportionate consumers of both unregulated and regulated medication. Women have been medicated or have self-medicated in an attempt to relieve the symptoms of social and psychological

stress often associated with oppression and oppressive conditions. Research has also indicated that until recently, in 1993, when the U.S. Food and Drug Administration (FDA) mandated that women be included in industry drug trials, women were excluded from the research trials for the drugs which are disproportionately prescribed for women (Hamilton & Jensvold, 1995; Baron-Faust, 1997).

This section of the paper has reviewed the disastrous affects that recommended dosages based on the research conducted on male subjects might produce in females. There is also evidence to support the contention that historically women have been the main consumers of patented and prescription medicines. Historically, research also shows that alcoholism and drug abuse have been viewed as a disease of men resulting in a paucity of information on female alcoholism and drug abuse and the most effective forms of treatment for female substance dependence.

Comorbidity

The past three decades has illuminated many diverse areas within women's lives. The dark corners that have hidden women's substance dependence are coming into focus. During the 1980's, the invisible female substance abuser began to take form as the growing interest in women's issues initiated research studies into this unacknowledged area of women's lives (Irwin & Stoner, 1991). The first half of the 1990's has added definition and shape to the female substance abuser.

A theme emerges from the shadows as the definition and shape of the female substance abuser takes form: Violence is often the predecessor of substance abuse

among women. “Findings indicate that nearly two-thirds of the women participating in outpatient substance abuse treatment have experienced sexual or physical abuse” (Gil-Rivas, et.al. p.100, 1996). The scope of abuse includes childhood physical and sexual abuse, domestic violence, date rape, and sexual harassment. This violence cuts a wide swath across every racial, social, age, and economic group.

A review of the numbers of women that are victims of violence is pertinent at this point. It s estimated that one of every three women will experience childhood sexual abuse (Herman, 1992). One in every four women will be a survivor of rape (Baron-Faust, 1997) and in college women, that number rises to nearly one in three (Testa & Livingston, 1999). One-third of women in the general population will be exposed to some type of physical or sexual assault during their lifetime (Gil-Rivas, et. al., 1996). Battering by a partner may occur at a rate of 25 percent-50 percent of women (McGrath, Keita, Strickland, & Russo, 1990). Every 15 seconds a woman is being sexually assaulted (Bauldauf, 1999). Seventy percent of all working women will experience some form of sexual harassment (McGrath, et. al., 1990). And even with these staggering statistics, professionals in the field of violence believe these numbers are an underestimation of actual occurrences (McGrath, et.al., 1990; Baron-Faust, 1997).

Exposure to violence in combination with other oppressive conditions is being established as a contributor to the development of specific mental disorders (Gil-Rivas, et. al., 1996; Nelson-Zpluko, et. al. 1995; Root, 1989; Baron-Faust, 1997;

Herman, 1992). While men and women suffer from similar rates of mental illness, certain disorders are more likely to be common in women (Hales & Hales, 1995; Baron-Faust, 1997). As discussed earlier in this paper, the fact that women have been given a second class status in society makes them more vulnerable to oppression and to the oppressive conditions that arise from second class status. "Studies demonstrate that oppressive conditions have a detrimental psychological and social effect on women" (Nelson-Zpluko, et. al. p. 48, 1995). Subsequently it should not be surprising that a growing body of research shows that violence, prevalent in oppressive conditions, results in risk factors that contribute to several of the mental illnesses commonly diagnosed in women (Baron-Faust, 1997; Herman, 1992; Root, 1989; Gil-Rivas, 1996; Davis & DiNitto, 1998).

These forms of mental illness include chemical dependency, post traumatic stress disorder (PTSD), depression, and eating disorders. Depression is the most common mental disorder among women (Baron-Faust, 1997; McGrath, et. al., 1990). Thirty to ninety percent of women who have been victims of physical/sexual abuse, whether as children or adults, will suffer from PTSD (Herman, 1992; Gil-Rivas, 1999; Baron-Faust, 1997). Ninety percent of people diagnosed with an eating disorder are women (Striegel-Moore, Silberstein, & Rodin, 1986).

It cannot be overlooked that many of these disorders overlap. Women diagnosed with an eating disorder may also suffer from depression and chemical dependency and may have been the victim of sexual abuse (Baron-Faust, 1997; CSAT, 1993;

Pipher, 1994; McGrath, et. al., 1990; Herman, 1992). Women who are victims of childhood violence and domestic violence may suffer from depression, PTSD and an eating disorder (Barrett & Trepper, 1991; CSAT, 1993). Women suffering from PTSD may also suffer from chemical dependency and depression (Herman, 1992).

Post Traumatic Stress Disorder

This section of the paper will first examine women and post traumatic stress disorder. PTSD is defined as a long-lasting, extreme reaction to a traumatic event which may cause the person to keep reliving the event with nightmares or flashbacks, often retreating into emotional numbness (Baron-Faust, 1997). The DSM-IV (1994) includes symptoms for PTSD as "persistent re-experiencing of the traumatic event, persistent avoidance of stimuli associated with the traumatic event, numbing of general responsiveness and persistent symptoms of increased arousal" (p. 424).

When PTSD was first included in the DSM-IV in 1980, traumatic event were described as "…outside the range of human events" (Herman, p.33, 1992). For most of this century, the diagnosis of PTSD was most often given to war veterans. Only after the women's movement in the 1970's generated the explosion of research into women's issues, several of which have already been discussed in this paper, was the truth about PTSD exposed. "The most common PTSD's are those not of men of war but of women in civilian life" (Herman, p.28, 1992). Explanation for the ignorance of PTSD and women can, again be found by reviewing history.

Domestic violence goes hand-in-hand with the 19th and 20th centuries beliefs surrounding the "family ideals" (Pleck, 1987). These beliefs centered around domestic privacy, and in actuality, the idea that the family world should be separate from the public world dates back to Aristotle (Pleck, 1987). "The cherished value of privacy created a powerful barrier to consciousness and rendered women's reality practically invisible" (Herman, p. 30, 1992). Humiliation, ridicule, and disbelief kept women ashamed and silent.

This paper offers a second explanation on why the connection between women and PTSD went unrecognized: The discrepancy between the definitions of mentally and physically health males and females. Freud dismissed the sexual molestation of his female clients as fantasy (Herman, 1992; Ehrenreich & English, 1978). Psychoanalysis interpreted claims of abuse with images of the seductive daughter, the lying hysteric, and the nagging wife (Pleck, 1987). A disciple of Freud, Helene Deutsch, interpreted abuse as female masochism. "Her concept of masochism seemed to explain why women who were abused stayed with an assailant – they secretly enjoyed the pain that was inflicted upon them" (Pleck, p. 159, 1987). Deutsch held the belief that masochism was "…a central element in the psychology of all women" (Pleck, p. 158, 1987). Researchers in the 1960's investigating battered women found these women to be "castrating," "passive," "dependent," "frigid," "self-defeating," hypochondriacs," and "indecisive" (Herman, pp. 116-117, 1992).

Violent abuse was kept hidden because it was part of the "private" sphere of family life and incest and childhood assaults were dismissed as fantasy. Recipients of violence enjoyed the pain inflicted upon them. Battered women were seen as passive, self-defeating, and indecisive. This paper reiterates; oppression can take many forms.

"Psychological trauma is an affliction of the powerless" (Herman, p. 33, 1992). The terror that accompanies violence and threats of violence requires a constant state of alertness. The normal course of development is no longer possible because even when the danger is past, people relive the event as if it were occurring in the present. Trauma produces long-lasting and profound changes in emotions, cognition, and memory (Herman, 1992).

The results of the repression of emotions for survivors of traumatic violence are complicated. "Sexual trauma has been found to be connected to the highest rate of PTSD" (Davis & Wood, p. 123, 1998). Childhood sexual abuse and domestic violence is associated with a higher incidence of substance abuse (Goldberg, 1995). Childhood survivors of traumatic violence are at great risk for repeated victimization as an adult. "The risk of rape, sexual harassment, or battering, though high for all women, is approximately doubled for survivors of childhood sexual abuse" (Herman, p. 111, 1992). Rates of victimization histories for women receiving treatment for the eating disorder bulimia, are double that of the general population (McGrath, et. al., 1990). Many of the symptoms of persons with a

primary diagnosis of depression (i.e.: helplessness, hopelessness, a restricted range of affect) are shared with victims of violence (McGrath, et. al., 1990).

Depression

Depression is the most common mental disorder among women (Baron-Faust, 1997). The risk for women developing depression exceeds that of men by two to one (McGrath, et. al.,1990). At least seven million women are thought to be suffering with a diagnosable depression (McGrath, et. al., 1990; Baron-Faust, 1997). Most will go untreated (McGrath, et. al., 1990). Just what is the definition of depression?

Defining depression is complicated but it is generally based on having five (or more) symptoms every day for more than two weeks "…which represent a change from previous functioning and cause significant distress or impairment in work, family, or personal relationships" (Baron-Faust, p. 24, 1997). Some of the common symptoms include sad mood most of the day, loss of interest or pleasure, decreased energy, difficulty sleeping, difficulty concentrating and making decisions, feelings of hopelessness and helplessness, and somatic complaints (Baron-Faust, 1997; American Psychological Association, 1994; Nolen-Hocksema, 1990; McGrath, et.al.,1990). Various subtypes of depressive disorder are also recognized by the APA: These include bipolar, dysthmia, adjustment disorder with depressed mood, organic disorder, and major depressive disorder. "Women are at higher risk for most types of depression" (McGrath, et. al., 1990; Nolen-Hoeksema, 1990). This

paper will limit its discussion to assessing the current knowledge of gender differences in depression disorder/major depression disorder.

It is only recently, as with substance abuse, PTSD, and pharmacology, that gender differences in depression have been recognized making it difficult to draw firm conclusions on just how women's depression differs from that of men (McGrath, et. al., 1990). Recent research is now showing the etiology of women's depression is different from that of men (McGrath, et. al., 1990; Nolen-Hoeksema, 1990). While it is known that all women from most countries in the age groups between 18-64 are much more likely than men to be depressed, biological factors may be a possible cause as many of these factors are unique experiences of women (McGrath, et. al., 1990; Nolen-Hocksema, 1990). Menstruation, pregnancy, childbirth, and menopause have been suggested as risk factors for women's higher rates of depression brought on by the imbalances or changes in hormone levels (Baron-Faust, 1997; Nolen-Hocksema, 1990; McGrath, et. al., 1990). Other risk factors suggested as contributing to women's higher rates of depression include different personality traits of men and women and social and cultural roles and status (McGrath, et. al., 1990; Nolen-Hocksema, 1990).

As previously discussed in this paper, the biological differences between males and females have often been translated into negative explanations concerning women's physical and mental health. "In the 19th century and earlier in history, depression and anxiety in women were usually viewed either as inevitable consequences of women's inferior anatomy or as the consequences of shirking the

natural feminine role" (Nolen-Hocksema, p. 16, 1990). It was commonly believed that a woman's reproductive system overpowered her brain and during menstruation, complete bed rest was recommended to avoid insanity (Ehrenreich & English, 1978). "In fact, the theories which guided the doctor's practices from the late 19th century to the early 20th century held that women's normal state was to be sick" (Ehrenreich & English, p. 99, 1978). The ideas surrounding a woman's health were taken as fact but with no empirical evidence (Ehrenreich & English, 1978) and there is presently little evidence for biological factors explaining women's higher rate of depression (Nolen-Hocksema, 1990).

Another area that has received considerable attention in the attempt to explain women's higher risk for depression is personality theory. As discussed earlier, gender role socialization for women produces a variety of maladaptive characteristics that raise the risk of depression for women (McGrath, et. al., 1990). Also known as social-role theory, gender socialization allows for the many subtle and blatant ways women are discriminated against (Nolen-Hocksema, 1990; McGrath, et. al., 1990).

This paper has previously examined the subtle and blatant ways women are discriminated against: Sexual harassment; work inside the home undervalued; discrimination in the job market and women earning 75 cents to every dollar earned by men, often resulting in poverty and a lack of health insurance plus the prevalence of victimization of women. "Studies indicate that even when women escape overt sex discrimination, they face covert discrimination in the form of negative

evaluations and segregation into low-paying jobs" (Nolen-Hocksema, p. 85,1990). "Poverty is the pathway to depression. Seventy per cent of the U.S. population (annual income of $5,776 or below) are women and children" (McGrath, et. al., p. XII, 1990). Gender, paired with its discrimination and oppression, appears to be a significant risk factor for higher depression rates in women.

The strongest predictor of alcohol dependence in women is depression (McGrath, et. al., 1990). Depression has often been observed in eating disordered patients (McGrath, et. al., 1990). Adults suffering with PTSD from child abuse often find relief from painful memories and flashbacks by altering those affective states through purging and vomiting, compulsive risk taking, and the use of drugs (Herman, 1992).

Eating Disorders

Eating disorders fall into three categories: anorexia nervosa, in which people eat very little to nothing to achieve and maintain a low body weight; bulimia nervosa, in which people eat too much and then try to expel the food by purging, excessive exercise, or fasting; binge eating disorder defined as compulsive overeating with no attempts to purge (Baron-Faust, 1997; Hsu, 1990; American Anorexia Bulimia Association (AABA), 1999). "Eating disorders are a form of mental illness in which a person's body image becomes so distorted (usually because of excessive fear of being fat) that their eating habits become dangerously abnormal" (Baron-Faust, p. 132, 1997).

More than five million Americans suffer from eating disorders (AABA, 1999). Ninety percent of those with eating disorders are women (Striegel-Moore, et. al., 1986; Borysenko, 1996). It is estimated that 10 percent of women between the ages of 13-30 may suffer from eating disorders (Baron-Faust, 1997; Wolf, 1991;Striegel-Moore, et. al., 1986). One percent of adolescent girls will develop anorexia and two to three percent of women develop bulimia, with the number as high as 20 percent among college-age women (Orenstein, 1994; Baron-Faust, 1997; Striegel-Moore, et. al.,1986). One in ten eating disorders leads to death by starvation, cardiac arrest, or suicide (Baron-Faust, 1997). Many with anorexia and bulimia also suffer from depression, PTSD, and struggle with addictions to alcohol and drugs (Herman, 1992; Hsu, 1990; Baron-Faust, 1997).

The distinction between anorexia nervosa and bulimia nervosa, as with depression, chemical dependency, and PTSD, is not clear-cut (Hsu, 1990). “While anorexia nervosa can be distinguished from bulimia by the body weight being at least 15 percent below normal weight for age and height, many anorexics may, in time, develop bulimia while 50 percent of normal-weight bulimics have a history of anorexia nervosa” (Hsu, p.7, 1990). After two years from the onset of restrictive anorexia, 40 percent of patients will become bulimic as hunger becomes unbearable (Hsu, 1990).

The onset of an eating disorder will often coincide with dieting. “The disorders almost always begin with dieting” (Hsu, p. 14, 1990). “As many as 40 percent of American women are trying to lose weight at any given time” (Baron-Faust, p. 132,

1997). The prevalence of eating disorders in a population consisting of 90 percent women must be examined. (Borysenko, 1996). “A key factor that places someone at risk for developing an eating disorder is being a woman” (Striegel-Moore, et.al, p. 246, 1986). This paper has repeatedly emphasized gender socialization and its resulting influence in the etiology and reinforcement of mental disorders discussed in this paper that are prevalent among women. How has gender socialization and this culture impacted and influenced eating disorders?

While women have been historically viewed as less physically and mentally healthy than males, women have at the same time been socialized to believe that their body is their most valuable commodity (Orenstein, 1994). “Beauty is the defining characteristic for the American woman” (Pipher, p. 183, 1994). Yet, beauty is defined by the culture and as the culture changes so does the definition of beauty.

Dieting and thinness began to be a preoccupation of women when American women won the right to vote (Wolf, 1991) but the preoccupation faded with the Great Depression in the 1930’s when being thin represented poverty. After World War II, with men coming home from the war, women working in factories were once more, designated to the “private/domestic sphere” and full-figures were again the norm (Wolf, 1991; Pipher, 1994). The recent economic, educational, and legal gains by women, initiated since the 1970’s, have been tempered by an almost cult-like devotion to thinness.

"We live in a society that associates thinness with success, self-control, strength, and most significantly, masculinity; we see fat as synonymous with failure, sloth, weakness, and feminine fecundity" (Orenstein, p. 94, 1994). In the thirty years since the second-wave of the women's movement, the "ideal woman" has become thinner with fashion models weighing 25 percent less and 9 percent taller than the average woman (Wolf, 1991). The "super woman" of the 1990's has added even further requirements to strive for as thin is also associated with career achievement, multiple role success, and beauty (Hart & Kenny, 1997). "…cultural pressures concerning physical appearance and achievement in multiple roles negatively impacts the psychological well-being of women…" (Hart & Kenney, p. 473, 1997). Women and girls compare their bodies to cultural ideals and are dissatisfied with themselves (Pipher, 1994).

"The diet industry takes in over $40 billion each year and is still growing" (AABA, 1999). "Before age 13, 80 percent of girls have already been on a weight-loss diet, compared to 10 percent of boys" (Striegel-Moore, et. al., p. 255 1986). The cultural messages to girls and women that success is synonymous with thinness and beauty are omnipresent in the media. Books, magazines, television, Movies and advertisements reinforce what it means to be female and often that message implies that what's on the outside (appearance) is more important than what is on the inside (Currie, 1997; Wolf, 1991).

When girls and women cannot juggle the "super woman" ideal and all that it entails or cannot attain the ideal woman appearance, the ramifications are often loss

of self-esteem, a sense of not being in control, and helplessness (Pipher, 1994). As previously discussed in this paper, these affects are also symptoms of depression. "Perhaps as many as 60 percent of eating disorder patients meet criteria for depression" (Hsu, p.6, 1990). "Depression was often observed in eating disorder patients and on follow-up with these patients" (McGrath, et. al., p. 92, 1992). Also, as previously discussed, drugs and alcohol are commonly used in an attempt to self-medicate negative affects. "Some 40 percent of bulimics also abuse diet pills, alcohol, and/or street drugs" (Hsu, p. 16, 1990).

Another area of research into the etiology of eating disorders finds correlations between childhood sexual abuse and eating disorders. "In one study of women undergoing outpatient treatment for bulimia, rates of victimization histories were roughly double that of the general population" (McGrath, et. al., p. 31, 1990). Further research (Rogers, 1995) reports that approximately 40 to 50 percent of eating disordered women describe sexual abuse in child or adulthood. Sexual abuse, in reality, is the powerful over the powerless and research into eating disordered women is exploring the connection of women attempting to regain a sense of control in their lives by exerting their power over food intake and their weight (Rogers, 1995). Again, it would be irresponsible to ignore how the mental disorders prevalent in women are enmeshed. Many women with anorexia and bulimia may suffer from depression, PTSD, and may also struggle with addictions to alcohol and drugs (Herman, 1992; Hsu, 1990; Baron-Faust, 1997).

Substance Dependence

While studies for the etiology of alcoholism and other drug abuse have shown a genetic link for the vulnerability to the disease, the majority of the studies used male subjects. The role of genetic factors in the etiology of female alcoholism and drug use are unclear and contradictory (Davis & DiNitto, 1998). Researchers identify two types of alcoholism: Type I is a more common, milder form that occurs in both males and females; and Type II (also known as male limited) that is a more severe form (Davis & DiNitto, 1998). While research is still limited in female genetic etiology, research findings are indicating that "…women are less susceptible to the more severe form, Type I" (Davis & DiNitto, p. 411, 1998).

However, studies within the last thirty years, as with increased interest in other areas of women's health, have made important strides into understanding women and alcoholism and other drug abuse. It is now known that there are definite metabolic differences that produce what is called the "telescoping effect" where women develop alcoholism more rapidly than men (Vaillant, 1995; Davis & DiNitto, 1998). "Women reportedly experience greater physiological impairment earlier in their drinking careers than men, even though they may consume less alcohol" (Davis & DiNitto, p. 412, 1998). Physical impairment includes hypertension and cardiovascular disease, liver disease, overdoses, accidents, and sexual dysfunction (Baron-Faust, 1997; Davis & DiNitto, 1998; Vaillant, 1995). Female alcoholics are twice as likely to die as male alcoholics in the same age group, states Anne Geller, Chief of the Smithers Addiction Treatment and Training

Center in New York city (Baron-Faust, 1997). "Indeed, women who die from alcoholism and its direct sequelae do so an estimated 11 years earlier than their male counterparts" (Vaillant, p. 124, 1995).

Women's smaller size and a lower ratio of body water to fat is one reason for higher risk of physiological damage (Vaillant, 1995; Davis & DiNitto, 1998; Baron-Faust, 1997). Another reason may be that women are more likely than men to also be using psychotropic drugs at the same time they are drinking (Vaillant, 1995). This tendency to use psychoactive drugs in combination with alcohol may find its origins in some of the issues previously discussed in this paper.

There are stronger social sanctions against women drinking heavily (Vaillant, 1995; Celentano & McQueen, 1984; Davis & DiNitto, 1998, Kandall, 1996). "For example, in popular literature and movies, intoxication in men is considered a source of great merriment; intoxication in women amuses no one" (Vaillant, p. 123, 1995). This negative attitude is universal in that both sexes and all social classes agree that drunken behavior by a woman is considered more deviant than drunken behavior by a man (Davis & DiNitto, 1998). Women substance abusers are considered to be unfeminine and promiscuous (Kandall, 1996).

This stigmatization has serious consequences for women. A diagnosis for substance use is more likely to be missed in women. "In primary care settings, women's alcohol-related problems are less likely than men's to be recognized and addressed by health care providers (23 % compared with 67% in one study)" (Bradley, Boyd-Wickezer, Powell, & Burman, p.166, 1998). Rather than

addressing alcohol-related problems, women are often treated for symptoms of depression, anxiety, sleeping problems, and somatic complaints with psychotropic drugs (Kandall, 1996; Davis & DiNitto, 1998; Baron-Faust, 1997).

Historically, women have been medicated and have self-medicated and often, for erroneous reasons. Viewed as less mentally and physically healthy than men, psychopharmacological treatment has been used to treat symptoms that have often been socially induced versus physically necessary (Bernandez, 1980; Mowbray, 1995; Kandall, 1996). The results have been a creation and perpetuation of misinformation concerning women's physical and mental health, a lack of proper diagnosing of real disease, and a propensity for multiple substance use (use of more than one mood-altering substance) in women (Celantano & McQueen, 1984; Kandall, 1996). "Although the type of licit drug used and patterns of use vary somewhat according to age, geographical location, socioeconomic background, and educational level, rates of licit drug abuse are greater for women than men in every age group, in each geographical location, and at every socioeconomic level" (Nelson-Zpluko, et. al., p. 46, 1995). Other research (Celentano & McQueen, 1984) suggests that women more frequently have multiple substance abuse.

A further complication for women abusing multiple substances, which could account for more accidental deaths for women than men (Vaillant, 1995), is that more women use prescription drugs with alcohol. Alcohol in combination with other drugs was the most frequently listed cause of death in a survey by the National Institute of Drug Abuse (NIDA). As already discussed, most drug testing

has used males in studies for correct dosage. Further studies using females showing that dosages for males may be too high for women, may contribute to more accidents and higher death rates (Hamilton & Jensvold, 1995).

Stigmatization of women substance users also complicates identification for women at risk for addiction. "Chemically dependent women are also more likely than men to use drugs in isolation and in private rather than in public places" (Nelson-Zpluko, et. al., p. 46, 1995). The social norm for abstinence is powerful. Not only do these norms influence how society views female substance abuse but also how the substance abuser views herself. " Substance abusing women experience higher levels of guilt, shame, depression, and anxiety about their addiction than men" (Nelson-Zpluko, et. al., p. 47, 1995). Because of the social stigmatization, a woman may very well try to keep the substance abuse a secret.

Family relationships play an important role in determining whether or not a woman becomes addicted and also whether a woman seeks treatment. "It is more likely than not that addicted women come from families in which substances were used as a primary coping strategy by one or more family members (Nelson-Zpluko, et. al., p. 46, 1995). There is also research indicating that having a spouse or partner who abuses substances is more likely to generate substance abuse in women than in men (Davis & DiNitto, 1998; Goldberg, 1995). "Some research contends that a relationship with an addicted male is the greatest risk factor predisposing a woman's addiction" (Davis & DiNitto, p. 418, 1998). These same relationships may discourage women from obtaining treatment. As women are often the primary

caretakers of children, family members may view her participation in treatment as a threat to her ability to care for the family (Goldberg, 1995).

Once again, the subject of violence and the victimization of women must be discussed. Violence could be another explanation for women's higher rate of accidents and death. "Domestic abuse is believed to be the largest cause of injuries requiring hospitalization among women in the U.S." (Goldberg, p. 792, 1995). "Fifty-two percent of all women murdered each year are killed by spouses or intimate acquaintances" (Baron-Faust, p. 172, 1997). Women who do report domestic abuse do so often at the risk of their lives (Baron-Faust, 1997). Women often stay in abusive relationships because they have nowhere to go, fear for the safety of their children, and do not have the financial resources to leave (Baron-Faust, 1997; Goldberg, 1995). "Drug abuse, for many women, results from attempts to cope with oppressive conditions" (Nelson-Zpluko, et.al., p. 48, 1995). All of the previously discussed issues within this paper result in formidable barriers to treatment for women (Goldberg, 1995; Root, 1989; Nelson-Zpluko, et.al., 1995; Davis & DiNitto, 1998; Celentano & McQueen, 1984).

Brief History of Traditional Substance Abuse Treatment

The historic national substance abuse treatment trend has been based on a male model. This should come as no surprise as this paper has previously discussed many areas in which the male model has been considered the norm. Mental health is one area where the ideal for a "healthy, mature adult" was based on male characteristics (Lips, 1993). Another area was the diagnosis for post traumatic

stress syndrome in which it was believed to be a disorder effecting war veterans, while women with the same symptoms were diagnosed with hysteria (Herman, 1992). The safety testing for new medications and dosages in most studies done before 1993 used the male model as the norm (Hamilton & Jensvold, 1995). Research on addictions has typically used the male addict as the norm when studying the etiology and effective treatment for recovery from addictions (Davis & DiNitto, 1998; Nelson-Zpluko, et. al., 1995; Kasl, 1992; Kandall, 1996; Goldberg, 1995).

Since its conception in the late 1930's, Alcoholics Anonymous (AA) and its 12-Step programs, designed and originated to meet the needs of white, middle-class male alcoholics, has dominated the recovery field (Kasl, 1992). The precedent to 12-Step programs was a non-denominational evangelical movement that was active in the early 1900's through the 1930's called the Oxford Group (Kasl, 1992). "It started as a small group of mostly men coming from a strong Christian background who hoped to promote change in the world through honest, moral principals. Unfortunately, the relationships were locked into sex-role stereotypes, so that women were taught to 'serve' and take a secondary role" (Kasl, p. 139, 1992). Bill Wilson, known as the father of AA, was an early member of the Oxford Group. Wilson separated from the Oxford Group to form his 12-Step program known as the Big Book. His 12-Steps were based on his experiences with one hundred mostly white and professional alcoholic men (Kasl, 1992).

From the 1960's through the 1980's, the conception of alcoholism was based on the premise that it was a unitary disease, distinct from normality, and stemming from a biological incapacity of an individual to regulate the use of alcohol (Miller & Willoughby, 1997). In 1952, based on interviews with over two thousand male members of AA, Jellinek, a pioneer in alcoholism research, formed a progression of the symptoms of alcoholism known as Jellinek's Curve (Miller & Willoughby, 1997). In 1960, Jellinek renounced this unitary model of alcoholism and proposed instead that there were a variety of different types of substance abuse problems (Miller & Willoughby, 1997). The DSM-III revised its label of alcoholism to alcohol abuse and alcohol dependence in 1980.

It is pertinent to remember that the vast majority of research done before the 1980's was collected on the male model of a substance abuse and that only in the past 20 years have studies on the female substance abuser been conducted. However, 12-Step programs have become the framework of most self-help groups that are recommended as support in recovery (Forth-Finegan, 1991). The numbers of women using AA as a tool for recovery has grown considerably and it is estimated that 30 percent of its members are now women (Davis & DiNitto, 1998). There has also been an emergence of women-only groups in the past few years. AA and 12-Step programs have many proponents and opponents. Proponents believe that this program has literally saved their lives. The 12-Step belief system and AA slogans have become a recipe for healing (Kasl, 1992). For others, the slogans and belief system are too rigid, too religious, insensitive, and dominating.

“Historically, chemical dependency treatment services suffer the same male designed, male oriented, and male dominated social stigmas that have affected other areas of our culture” (Irwin & Stoner, p. 123, 1991). Many women find AA and 12-Step ideologies oppressing and the patriarchal language offensive (Hall, 1994). “Alcoholics Anonymous, which promotes reliance on a male deity, is grounded in patriarchal thinking; some believe this philosophy promotes female dependence on others and discourages self-reliance” (Nelson-Zpliko, et. al., p. 49, 1995). Women and minorities have found that being in a group with white men replicates society’s hierarchy; white men often dominate the group by talking the most, interrupting others, and are often insensitive to views and experiences other than their own (Kasl, 1992; Kandall, 1996; Hall, 1994). “Few programs have been designed specifically for women, fewer have offered child care, and rural programs for women have been virtually unknown” (Avé-Lallemant, 1997). Treatment programs that include men are often difficult for women who have been victims of sexual abuse (Goldberg, 1995; Root, 1989).

While AA and 12-Step programs are valuable resources, this comprehensive qualitative evaluation of the literature on women, substance abuse, and treatment, has shown that not everyone will find them helpful and accepting. “Abstinence is most often the singular goal and sole treatment outcome that is valued and measured” (LaFave & Echols, p. 346, 1999). It would be an oversight to consider

that the presenting problems that women substance abusers bring into alcohol and drug abuse treatment have been solved or eliminated solely by sobriety or abstinence from alcohol and/or drugs, therefore resulting in recovery. "In other words, while relapse has usually been defined in terms of abstinence or total cessation of addictive behavior, it is important to understand that cessation of an addictive activity involves more than abstinence" (Young, p. 259, 1990). Treatment programs must include a balance of life skills that bring meaning and productivity to those receiving treatment. Treatment providers need to become aware of the obstacles and limitations for women in traditional recovery programs.

Suggestions for Nontraditional Substance Abuse Treatment

Women have often been labeled by treatment providers as resistant, non-compliant, difficult, and unresponsive to treatment (Nelson-Zpluko, et. al., 1995; Goldberg, 1995; Root, 1989). "High recidivism and relapse rates occur among the entire population of substance abusers seeking treatment but it appears that women are particularly vulnerable to relapse" (Glover, 1999; LaFave & Echols, 1999). "Traditionally women have fared poorly in drug and alcohol treatment relative to men. Rates of entry into treatment, retention, and completion of treatment are significantly lower for female clients than male clients" (Nelson-Zpluko, et. al., p. 48, 1995). Why are failure rates for women in traditional treatment programs so high?

Many professionals in the field of women's recovery find the programs themselves are at fault. "Women's failure rates in traditional drug treatment

programs are not surprising given that programs have been designed primarily by males for male clients and that their approaches have been informed by research conducted on male substance abusing populations" (Nelson-Zpluko, et. al., p. 49, 1995). Traditional treatment is often confrontational and "…it often places its emphasis on the powerlessness of the individual" (Glover, p. 282, 1999).

Based on the literature reviewed for this paper, emphasis on powerlessness would appear to be counterproductive to the recovery process for women. For those women suffering from PTSD and trauma, recovery is based upon the empowerment of the survivor (Herman, 1992). "Trauma robs the victim of a sense of power and control; the guiding principle of recovery is to restore power and control to the survivor" (Herman, p. 159, 1992). For women recovering from drug abuse, empowerment is stressed. If a drug is appealing to women precisely because it gives and illusion of power in circumstances where women's experiences of powerlessness may be absolute, then it would follow that drug treatment programs for women must empower the disempowered" (Walker, Eric, Pivnick & Drucker, p. 15, 1991).

As previously discussed in several sections of this paper, the gender roles of women, paired with the discrimination and oppression that often accompanies the female role, are significant risk factors for depression. That these factors seem beyond a person's control may result in the feelings of helplessness and hopelessness often associated with depression. "For culturally disempowered women, recovery begins with the experience of empowerment – recognizing and embracing the power to shape one's own destiny" (LaFave & Echols, p. 346, 1999). Education

surrounding the prevailing gender beliefs and their effects, both culturally and personally, may often prove empowering (Nolen-Hocksema, 1990).

Another obstacle for women's participation in treatment is a lack of childcare. "The most common cited reason for women to leave treatment prematurely was related to the care of dependent children" (Nelson-Zpluko, et. al., 0. 48, 1995). Very few residential treatment programs provide accommodations for children (Goldberg, 1995). The disproportionate number of single, female parents in combination with the high poverty levels that often are a part of that role contributes to the obstacles of participating in treatment seem practically insurmountable. The need for comprehensive treatment is imperative for this population (CSAT, 1993). Programs need to not only deal with substance abuse but with such services as help with housing, education, medical, and family counseling (Goldberg, 1989; Hser, et. a., 1999).

"Clients who received the desired services stayed in treatment significantly longer and showed more improvement in the corresponding problem area than those who did not receive the desired services" (Hser, et. al., p. 304, 1999). Some innovative programs call the comprehensive services "wrap around" services as they encompass and try to solve such issues as transportation, legal services, childcare, and parenting classes.

The issue of comorbidity is another obstacle for women receiving effective treatment. Comorbidity and the emphasis on abstinence may trigger relapse and

exiting the treatment program. "There appears to be an inverse relationship between substance abuse and symptomology associated with the trauma (i.e.: intrusive experiences are less frequent and intense while the client is drinking, using drugs, or binge eating)" (Root, p. 545, 1989). "The emergence of childhood memories (from incest) may become a high-risk precipitating factor for relapse" (Young, p. 252, 1990). Women may be reluctant/ resistant to treatment in an effort to avoid the traumatic memories (Young, 1990). "From the view of the adult women who was incestuously abused as a child, substance use and abuse certainly does serve important functions" (Barrett & Trepper, p. 139, 1991). To facilitate with the healing from traumatic experiences, it is helpful for the survivor to form connections with others who had had similar experiences (Young, 1990).

This sharing of experiences can become problematic in traditional treatment programs. "Group interventions seem to be a type of treatment to which women with a history of incest respond" (Marotta & Asner, p. 321, 1999). However, "Women in traditional drug treatment state that the gender imbalance is most keenly felt in group therapy sessions in which there may be only one women in a group of ten or more members" (Nelson-Zpluko, et. al., p. 49, 1995). While the experience of sharing abuse experiences with others within a group setting facilitates in a woman understanding that she is not alone, if she is pressured into a public explanation within a mixed group, she may be left feeling violated once again (Nelson-Zpluko, et. al., 1995; Young, 1990).

All of these factors and obstacles for women seeking treatment are further complicated by the cultural stereotypes of women substance users, including the idea that it is worse for a women to use substances than it is for a man. Gradually the public is becoming aware of this false gender stereotype and there are a number of innovative treatment projects for women. As providers become aware of the problem areas for women finding and receiving effective treatment, changes can be implemented. Helpful suggestions for improving treatment programs for women were accumulated from this exhaustive analysis of the literature.

- Day treatment is recommended as it is more economical plus it allows a woman to adjust within her own environment (Goldberg, 1995).
- Provisions for childcare on the site of treatment is recommended as most helpful (Nelson-Zpluko, 1995; Goldberg, 1995).
- Further training for primary care physicians to recognize substance abuse, PTSD, depression, and eating disorders and how they interact. The further training would also help prevent inappropriate overmedication (Baron-Faust, 1997; Kandall, 1996; Goldberg, 1995).
- Different 'cut points' in screening questionnaires as these tools miss 41% to 62% of women with alcohol and drug dependence (Bradley, et. al., 1998).
- Comprehensive, team approaches that match clients needs with drug treatment services including vocational services, housing services, parenting skills, transportation, legal assistance, family counseling, and medical services (Hser, et. al., 1999; CSAT, 1993).

- Women's groups and women staff in treatment programs promotes positive role modeling, helps promote normality of feelings, and skill sharing (CSAT, 1993; Bernandez, 1980).
- Further education for human service providers to become advocates for female clients (Nelson-Zpluko, et. al., 1995).
- Prevention programs, not only anti-drug programs in schools but prevention of sexual and physical abuse of girls, as this is a major complication for women's mental health (Pipher, 1994; Goldberg, 1995).
- Education and reduction of the female stereotype as this is also a contributor to women's mental illnesses (Nolen-Hocksema, 1990).
- Additional research on the causes of women's substance abuse and additional research on effective treatment programs (Kandall, 1996; Goldberg, 1995).

New forms of treatment are being developed in response to the failure rates for women in treatment and many are proving to be efficacious. As women's realities are recognized, healthy coping strategies are being implemented both within treatment programs and within the society.

Chapter IV

Results

In the third chapter of this comprehensive qualitative analysis of the literature, information was provided regarding women, substance abuse, and treatment. It is now known that substance abuse and addiction are not restricted to men. The mental and physical definitions for the two genders were discussed. Included in the discussion were the implications of different mental and physical standards for men and women and what were the implications for women of these different standards throughout recent history. Also examined was the history of women and drug use, a history of the pharmaceutical industry, the comorbidity of prevalent mental disorders often diagnosed in women, and a history of traditional treatment programs. A number of suggestions were made to update treatment programs to include the treatment of problems prevalent in female recovery populations. This chapter will provide a summary of the important points discussed in chapter 3. When discussing each component, this researcher will refer the reader to the location in chapter 3 that the topic can be found. Page numbers will appear in parentheses. If the reader should want to review the topic that is summarized within this chapter, please refer to the specified pages.

Mental and Physical Definitions for Genders

Different standards of mental and physical health for males and females have historically influenced how each gender is viewed (pp. 19-20).

Brief History of Women and Substance Abuse

This section (pp. 20-24) explains the implications that the different standards of mental and physical health have generated for women. Information was presented on the prevalence of patented and regulated medications used by women. Some of the reasons for this drug use include an attempt to cope with the many forms of oppression women are subjected to plus the misinformation perpetuated by advertisements and the medical community.

Post WW II Brief History of Pharmaceutical Research and Industry

A discussion is presented (pp. 24-28) on the growth of the pharmaceutical companies as drugs were developed to treat mental illnesses. The negative implications for this growth examines how psychotropic drugs were heavily prescribed for women irregardless of the presenting symptoms. The research for studying effectiveness, side-effects, and dosages is also explored. That the majority of research studies used male samples has implications for female usage.

Comorbidity

The disorders that are prevalent among women in combination with substance abuse are introduced (pp. 28-31). Oppression, in many forms, has been found to contribute to several of the mental disorders commonly diagnosed in women. These disorders include post traumatic stress disorder, depression, eating disorders, and substance abuse. Differential diagnosis is often difficult because of comorbidity.

Post Traumatic Stress Disorder (PTSD)

PTSD and women was discussed (pp. 31-33). The definition of PTSD was given plus the history of the expansion of PTSD to include women who have experienced traumatic events. The prevalence of violence and victimization of women were discussed as were explanations for why PTSD was not expanded to include women until recently. Reasons given for the exclusion include the privacy of the family ideal and the early ideas postulated by Freud and Deutsch. Freud's theory for the recall of early sexual abuse by women was that the memories were fantasy while Deutsch's theory stated that women staying in abusive relationships did so because of masochistic tendencies.

Depression

The most common mental disorder among women was discussed in this section (pp. 34-37). The definition of depression was provided plus the different types of depression. Why women are at a higher risk for depression than men was examined. Again, the consequences for a different standard of mental and physical health for men and women was discussed as were the subtle and blatant ways that women are discriminated against that may produce depressive symptoms.

Eating Disorders

The third prevalent disorder diagnosed in women, eating disorders, was discussed (pp. 37-41). The definition of eating disorders was presented and the three types of eating disorders were explained. Explanations for this disorder, which is

almost primarily diagnosed in women, were offered. These included the ideal of thinness in this culture and the fact that women have been conditioned to view their bodies as their most valuable commodity. The impact of the media including the diet industry was examined. The prevalence of incest and sexual abuse survivors who suffer from bulimia were discussed.

Brief History of Traditional Substance Abuse Treatment

A synopsis of the history of substance abuse treatment was presented (pp. 46-49).This included a history of the conception of Alcoholics Anonymous and 12-Step programs plus a history of alcoholism as a disease concept. The prevalence of 12-Step programs as the norm for recovery programs was discussed and several complaints by opponents to the 12-Step method of treatment complaints were listed.

Suggestions for Nontraditional Substance abuse Treatment

Obstacles that women find difficult for receiving and staying in treatment were discussed (pp. 49-54). The emphasis on powerlessness in traditional alcohol and drug treatment programs proves to be a stumbling block for many women particularly for women who are also survivors of trauma and for those suffering depression. The gender roles and the gender stereotypes for women are problematic for traditional treatment and powerlessness. Lack of childcare is listed as the most common reason that women leave treatment early. “Wrap around” services are extremely helpful for women. Relapse and comorbidity are also common treatment failures. Groups are considered to be very helpful for women in recovery but groups

containing a mix of males and females are detrimental for many women. This section also included a lengthy list of recommendations that would increase the likelihood of women entering and benefiting from treatment.

<u>Implications</u>

A great deal of information has been presented in this comprehensive qualitative analysis of the literature surrounding women, substance abuse, and treatment. The focus of this section will be to make an attempt to coalesce the information to facilitate the professional in the field of substance abuse treatment who will serve women.

It is extremely important for substance abuse professionals to be aware of the complicated issues that women bring into treatment with them. Facilitators in the process of recovery need not only to be aware of the substance abuse itself, but also aware of the comorbidity of the mental disorders that are prevalent among women who use substances. Professionals need to understand that women are often self-medicating to ward off the affects of co-existing disorders.

Professionals also need to be aware of the complex relations between the structural features of our society and how these structures are often the cause of discrimination and oppression against women. The result of the discrimination and oppression may promote women using both licit and illicit drugs in a misguided attempt to cope with their feelings of helplessness and hopelessness. It is essential that professionals in the field of substance abuse recovery use their knowledge of societal conditions for women to advocate both politically and with research

facilities to decrease the risk of women developing substance abuse problems and to aid in finding effective treatment modalities.

If you are a professional working in the field of substance abuse recovery with a woman who is substance dependent, be aware that she may also have other disorders that have not been diagnosed. Along these same lines, it is important to know who to refer women to if comorbidity is suspected. Always be aware that the substance abuse may effectively camouflaging painful feelings that may come to the forefront with abstinence that may result in a high risk for relapse. Those feelings will need to be addressed in a compassionate manner, which means a flexible approach to treatment may be more effective.

Because the experiences, treatment needs, and treatment outcomes of women are different than those of men, it would be wise not to attempt to generalize across genders. Becoming aware of the differences and remaining sensitive to the differences will facilitate more compassionate and more effective treatment recovery programs for women.

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Appendix

The Twelve Steps of Alcoholic Anonymous

1. We admitted we were powerless over alcohol – that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God, as we understood Him.
4. Made a searching and fearless inventory of ourselves.
5. Admitted to God, ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove our shortcomings.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we have harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take a personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.