

Women Residents: Expanding Their Role to Increase Treatment Effectiveness in Substance Abuse Programs

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Abstract

It has long been noted that chemically dependent women have special needs that differ from the needs of chemically dependent men. A therapeutic community model, which has been found effective, suggests several changes in traditional treatment approaches. After intervention with our female-based therapeutic model, several positive changes occurred. Extremely disproportionate populations of males and females began to even out with female residents' length of stay increasing dramatically. Length of stay for male residents also increased by a significant amount. Success of treatment, as measured by the number of drug free ex-residents, also increased significantly for male and female populations.

Historically women have outnumbered men in their use of opium in the United States at a ratio of approximately two to one. Cuskey, Premkumar, and Sigel (1972) cite early studies completed in Florida, Iowa, Michigan, and Tennessee between 1877 and 1915 as all showing that the female rates of narcotic addiction were well above male rates. Before narcotics became illegal without a prescription, it was possible to use various over-the-counter medications that contained narcotics. After the passage of the Harrison Narcotic Act of 1914, a shift in the male/female narcotic use patterns was observed in that women's use of opium declined (Miller, 1983). After outlawing self-medication with narcotics, there was a shift from female to male predominance in opium use rates as well as a change of the source and circumstances of obtaining the drugs. Prescription drug use then became the primary form of drug taking for women such that by 1967 two-thirds of all medications prescribed were taken by adult women (Brecher, 1972).

It is difficult to get an accurate picture of female drug abuse patterns as treatment statistics are a primary source for identifying drug use patterns. Traditionally, women seek out and enter treatment programs less often than men (Gutierrez, Jonathan and Rhoades, 1981). Reasons that women do not seek treatment as often as men include social expectations and pressures, lack of adequate treatment facilities for women, and lack of facilities for the children of women, in treatment. Oftentimes, women are required to place their children in state foster homes so that they can enter a residential treatment facility.

HISTORY OF TREATMENT PROGRAMS FOR WOMEN

The National Institute on Drug Abuse established its Program for Women's Concerns in 1974. In 1976 a national conference on women's issues was held focusing on the identification of the treatment needs of women and the types of programs that would have positive impact on female drug abusers. Public Law 94-371 was passed in 1976 granting priority consideration for the funding of women's treatment and prevention programs (Beschner and Thompson, 1981).

A surprisingly low number of programs address special needs of women. In a study on the availability of drug treatment services for women across the United States, 35 programs were identified as offering special services for women in the areas of health, child care, vocational counseling, and employment. Of these programs, 25 were further investigated, in which a total of 547 women were involved in treatment. Seven of these 25 programs were residential drug free programs serving only women. These seven programs totaled 130 of the 547 women in treatment. Residential drug-free programs serving both men and women numbered three with a total of 42 women being serviced. The remainder of the 547 women were involved in women-only outpatient, men and women outpatient, and men and women outpatient methadone.

Furthermore, Reed, Beschner, and Mondanaro (1982) indicate that women have traditionally been undeserved and are at a disadvantage in most treatment programs. Often, women are dewed more negatively than men and their special biological and social needs are ignored and misunderstood.

Chemically dependent women have special needs that differ from those of chemically dependent men. "Generally, she is much sicker and harder to treat. Her relationships with men have been terrible. She has been used, sold, beaten, violated, conquered, derided and exploited" (Densen-Gerber, Wiener, and Hochstedler, 1972). Additionally, a significant percentage of the women experienced incest and molestation as children. Estimates of molestations have run as high as 60% in certain geographical areas for

women, as compared with up to 20% for men. This is consistent with the statistics from Odyssey House (Densen-Gerber, 1973). This is true also for professional women whose chemical dependency centers around prescription abuse (Miller, 1983). Nationally, therapeutic drug free communities have provided 75% more services to women than methadone treatment centers. However, even though these therapeutic communities include more than just heroin-dependent women, "across the therapeutic community scene, women in treatment are (more often than not) brutalized in a prevailing male-oriented, male-dominated environment." According to Levy and Dole (1974), "empirical and anecdotal evidence is mounting rapidly which points toward sexist attitudes and practices which directly cripple the attempts to effectively rehabilitate female clients and indirectly distort quality treatment of males as well."

It is recognized in our society that sexual abuse can have serious psychological effects. This issue is tragically underserved in treatment facilities. In a 1980 study (Wasnick, Schaffer, and Bencivengo), a random sampling of 50 drug dependent women discussed their treatment experiences. Eighty percent of them stated that counselors had never addressed any issues of sexuality; of the 10 women whose agencies did have women's groups, only two reported that the issue ever arose. Thirty-nine percent of these reported sexual harassment by male staff members. Considering that almost all rape victims experience a loss of safety, control, ability to trust, autonomy, self-esteem, and integrity, and that drug-dependent women statistically have a high rape and incest history, this lack of services is dismal indeed. Wasnick, Schaffer, and Bencivengo (1980) found that of 50 drug-dependent women, 70% of them had been raped *prior* to chemical dependency.

Despite these findings in a 2-year follow-up study of graduates and dropouts at Phoenix House, the psychological improvement for women was significantly larger than for men. Sixty percent of the women studied showed marked improvement on a battery of tests including the MMPI, over pretreatment status. All of them upon entering Phoenix House scored consistently lower than their male counterparts on the psychological battery of tests which were administered to both sexes (DeLeon and Jainchill, 1980). Furthermore, success and improvement was increased by time in program for both sexes. These data are also supported by a study of Synanon dropouts. Phoenix House and Synanon environments were traditionally male-dominated therapeutic communities. In particular, the need for child care/parenting services was not recognized. In Synanon, women generally had to wait a minimum of 18 months to have their children join them in treatment. Phoenix House does not provide child care at all. There is not a therapeutic community nationally that has a population consisting of 50% women/50% men.

AMITY, INC.: HISTORY AND PROCESS

Prior to August 1981 the Amity, Inc., program had been traditionally male dominated. For 5 years the average length of stay for women in treatment was 42 days. Children were not allowed to accompany their mothers; in fact, approximately 15% of mothers prior to August 1981 signed away custody under the pressure from courts to enter the program on drug-related charges. Mothers who completed treatment successfully regained custody of their children, but often only after several years and continual legal struggle. The atmosphere at Amity, Inc., prior to 1981 was not conducive to promoting positive change in men or women. Thus the following changes were introduced:

1. A female program director and additional female staff were hired for the intent of positive role modeling for the women. This also gave women residents a sense that they were important and that they had support.
2. Periodic women's groups were held. For the first 6 months there were not enough women to have a women's group, so informal one-to-one counseling sessions with women were held.
3. There was consistent emphasis in the environment on the way in which the men and women treated each other. Calling each other derogatory names outside of group was treated as a serious infraction of social mores of the program.
4. Within the group setting, both sexes were actively encouraged to air their prejudices, explore their histories, and engage in total self-disclosure relating to all aspects of life including sexual experiences. Which men were responsible for abortions became an issue as well as which women had them. Which women had been raped or experienced incest and molestation became an issue as well as which men had perpetrated such acts.
5. A Resident's Bill of Rights was drawn up, the first right being the right to be in a group with any other resident and with the program staff. Residents were given the right to complete freedom of speech in this forum (barring threats of violence) without fear of retaliation.
6. Jobs were not assigned on a stereotypical sex-role basis.
7. Seminars were given on a regular basis focusing on topics such as assertiveness training, survival skills, sexuality, current women's issues, politics, health promotion, and vocational opportunities.
8. In 1983 a woman counselor specifically responsible for overseeing the women's program was hired. The women's counselor specifically interviews women clients and organizes outreach to hospitals, outpatient-care facilities, and prisons to inform

women of the availability of services. Her responsibility is to ensure the overall provision of women's services, including scheduling, overseeing, and implementing treatment plans. With approximately 20% of the women having had abortions without follow-up visits and 70% not having had a pap smear in years, etc., the women's counselor follows up on each woman's medical history and needs. Working with the child care coordinator, she also aids women in seeking appropriate care for their children. Furthermore, she provides a significant proportion of the women's education as well as helping the women to resettle in the larger community, aiding them in finding jobs, and following up on the women graduates. The women's counselor documents and records all services provided specifically for women.

9. There has been expansion of ongoing women's groups including workshops and extended retreats. The purpose of women's groups is to provide a forum where honest communication with other women can develop, thereby fostering strong peer bonds, support, and cooperation.

10. Women were permitted to bring their children into treatment with them. An assessment of the situation was made prior to intake by the women's counselor and intake worker. If the assessment of the situation indicated that the children did not have a supportive, positive environment to stay in while the mother was in treatment, and the Amity, Inc., mother's program had space available, the children were permitted to live at the residential facility with the mother. Each child's case plan was assessed individually. Working with a supportive elementary school nearby the Amity Inc., facility, the school-age children work with the school psychologist and appropriate educational arrangements are made. For the preschool children, the mothers work closely with the children's coordinator at Amity, Inc. The mothers take turns working with the children under the supervision of the children's coordinator. Thus, each mother learns how to interact appropriately with her children while also being able to spend a great deal of time participating in treatment without the immediate presence or responsibility of her child. The mothers are also freed for parenting class, a formal lecture/seminar on child development and care held one evening per week. At mealtimes and recreational activities the children are often included in the residents' activities. With the introduction of children into the environment, all residents were instructed that their standard of behavior - including language, table manners, rough-housing, drug talk, and other "street behaviors" - had to improve.

Percent of women in
treatment at Amity

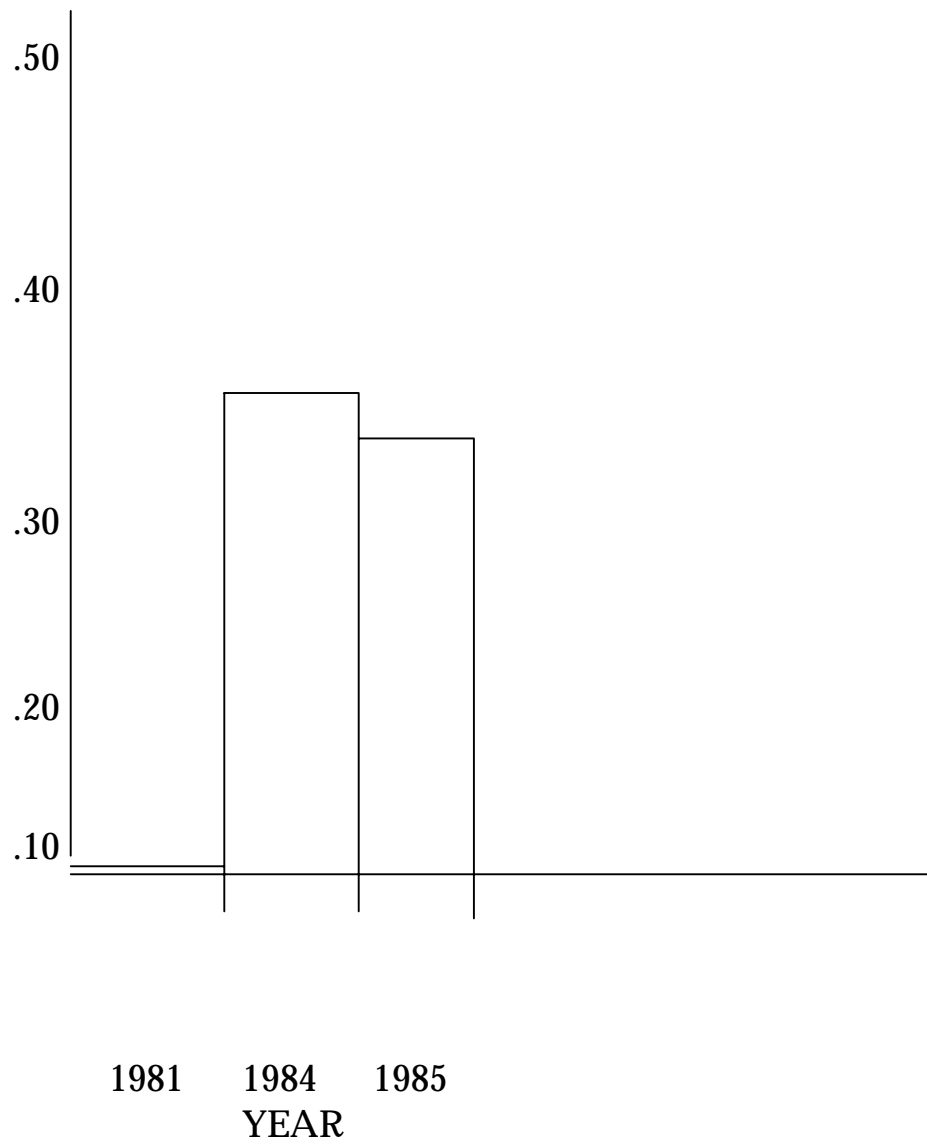


Fig. 1 Increase in percentage of women in residential treatment at Amity, by year.

RESULTS

After 3 months of consistent women's grouping at Amity, leadership emerged. A number of women took responsibility in calling groups not only for the women but for the men as well. There were displays of affection between the women without confusion stemming from previous prison/street relationships. These included writing notes to each other, setting up special dinners and serving each other, making each other presents, calling groups for each other, taking care of each other when sick, helping each other with child care, hugging, making public statements in house meetings of affection and commitments of friendships, and consistently including newer women. These results are consistent with the 16-month study of Mandel, Schulman, and Monterior (1979) in which effects of ongoing women's groups within a coed therapeutic community were examined.

Three out of the first five women to enter Amity, Inc., after institution of the changes graduated. Women's groups became progressively more honest as the number of women in the program increased. Sexual harassment between the male and female clients decreased. This was in large part due to the fact that women clients began to exercise their first right; that is, freedom of speech in the group without retaliation. A number of the male residents began supporting the women's viewpoint, particularly as they became intrinsic to the functioning of the community. Incidents of harassment that have occurred since the changeover are brought to the attention of the community in public meetings by both sexes.

In contrast to the original population in August 1981, in which .08% of the Amity residential population were women, the percentage of women in 1983 was 32%. This increase in the proportion of females to males at Amity, Inc., is impressive (see Fig. 1).

WOMEN RESIDENTS

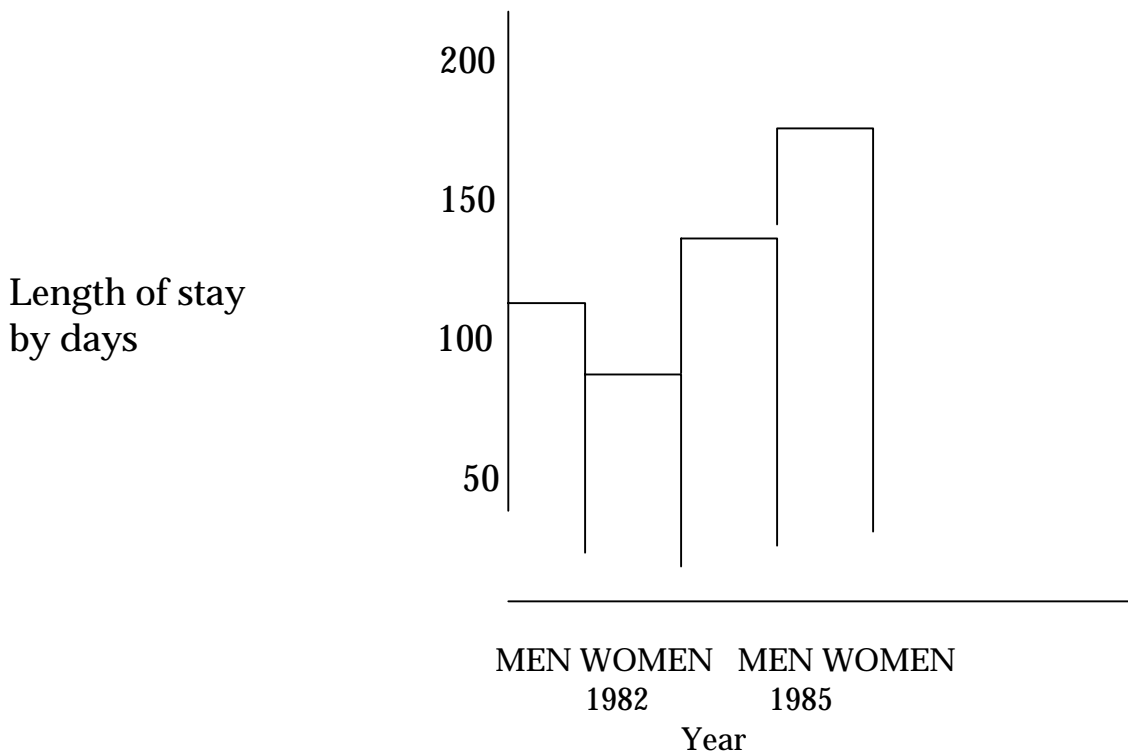


Fig. 2. Length of stay of female and male residents, by year.

Length of stay has increased for both men and women since 1981 (see Fig. 2). In 1982 the length of stay for women was lower than that of the combined population of men and women. By 1985 the average length of stay of women had increased to a greater extent than the combined population of men and women. Both statistics, however, significantly increased over time. Of the women who sought treatment in 1982 (1 year after the beginning of the specialized women's program), the average length of stay was 89 days. By 1985 the average length of stay was 158 days. In regards to the combined population of men and women, the average length of stay in 1982 was 103 days. An increase to 143 days for the combined population was observed by 1985.

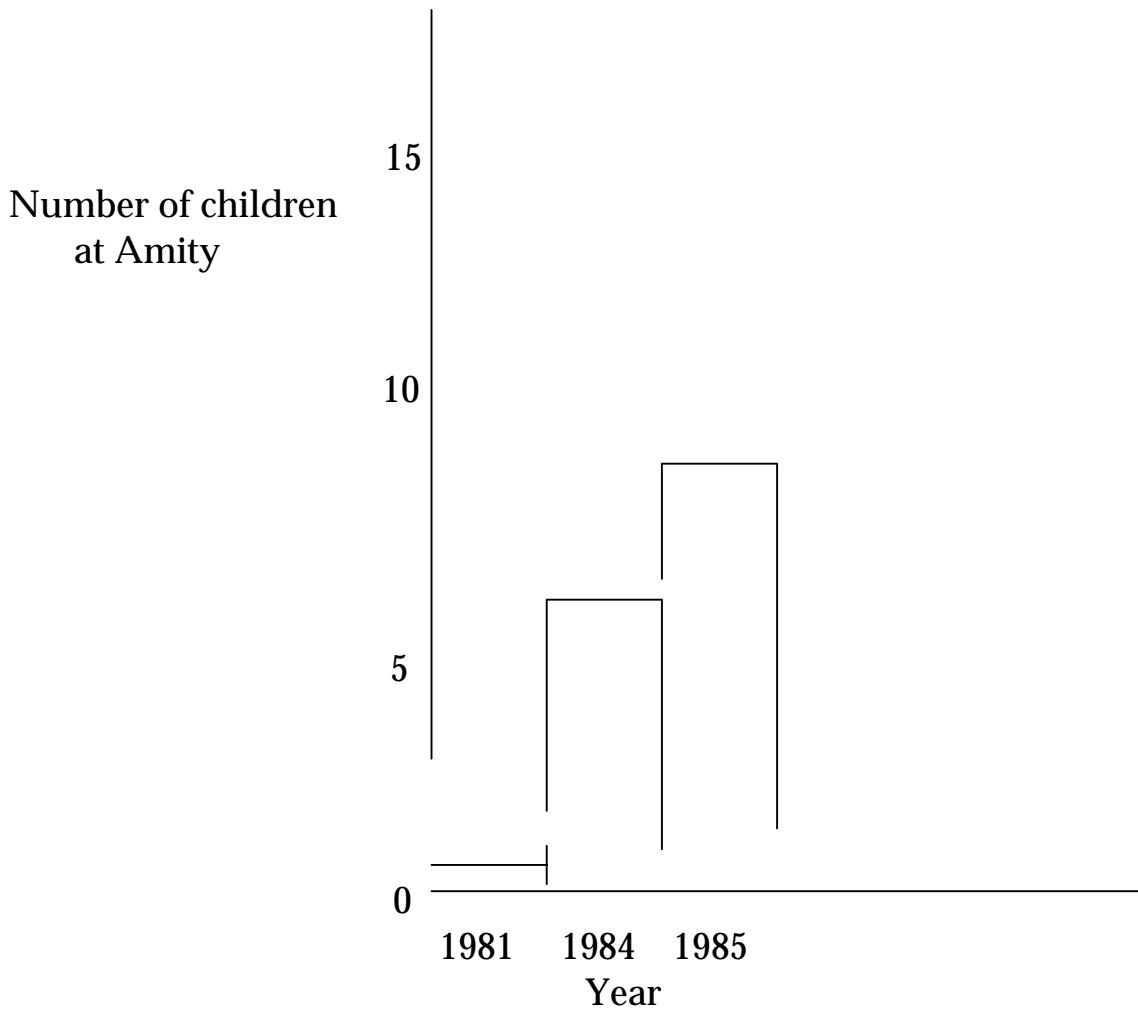


Fig. 3 Increase in number of children at Amity, by year.

Possible reasons for this effect may be that the functioning program met the needs of men better than women in 1982. By 1985 the Amity, Inc., program met the needs of women, particularly those with children, better than the overall population. In general,

needs of both males and females were better met, as evidenced by the dramatic increase in length of stay.

An increase in the number of children has been observed. In August 1981 there were no facilities for children of women residents. In 1984, 7 children were included in the Amity, Inc., population, and in 1985 the statistic grew to 10 children (see Fig. 3). Length of stay for mothers with children at Amity was higher than that of the overall production.

DISCUSSION

The programmatic changes at Amity have significantly affected the treatment outcomes of the women. In particular, the female/male client ratio, the presence of child care, the regularity of women's groups, and the availability of women's source material relating to a variety of women's issues have been cited by the women themselves as significant factors increasing their comfort in treatment.

Observations have been made that the more women strive toward wholeness, the easier it is for the men to develop and particularly to engage in self disclosure in groups. As the women began to feel comfortable talking about their childhood sexual abuse, an increasing percentage of men found it safe to talk about their childhood rapes and molestations that have subsequently colored their entire lives (usually by engaging in a variety of deviant behaviors). If childhood sexual abuse is a difficult subject for the women to disclose, it is taboo in our society for men to share such experiences. Jung (1964) mentions that frequently it is through some significant act of recognition from outside ourselves that we are able to find and accept our true selves, that "the shadow belongs to the light as the evil belongs to the good and vice versa," that within each of us is the male and the female principle, the animus and anima. Through the women's true acknowledgment of each other and the acceptance of themselves as women, a therapeutic safety is developing for the men that appears to be unprecedented. DeLeon and Jainchill (1980) note that female successes when administered the MMPI profile *altered* toward nondeviancy while for males successes the MAPI *improved* but remained unaltered. This population was a predominantly male-oriented therapeutic community. It is possible that where the strong female element is lacking and where the traditional mistreatment of women in therapeutic communities has not changed (e.g., minimal change in males' "street attitudes" toward women), the treatment of men is also significantly lacking.

Implications of this research suggest that women residents may play an important role in increasing the effectiveness of substance abuse treatment for men and women. If women in treatment are allowed to feel safe in addressing their treatment issues and demonstrate self-disclosure, treatment will be more successful not only for women but for men as well. Residential substance abuse treatment centers should strive to equalize male/female resident ratio. Staff training should be given focusing on the special needs of women residents and how involvement of women residents can increase program effectiveness.

Further research is needed to examine how the needs of female substance abusers can better be met. Furthermore, what aspects of treatment allow women to feel safe in therapy so that they may honestly address their personal issues should be explored.