

Evaluating, Treating and Monitoring the Female DUI Offender

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

Women and the State of Alcohol and Drug Studies

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

Consumption Patterns

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

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

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

DUI Prevalence Rates among Women

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

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

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

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

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

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

Profile of Female DUI Offenders

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

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

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

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

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

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

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

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

Female Alcohol/Drug Physiology

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

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

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

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

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

Incidence and Risk of Substance Use Disorders in Women

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

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

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

Onset of AOD Problems

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

Female Patterns of Substance Dependence

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

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

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

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

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

Ethnic/Gender Differences

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

Addiction and Psychiatric Illness

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

Victimization as a Risk Factor

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

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

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

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

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

Obstacles to Treatment

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

Treatment Entry Decisions

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

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

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

Female Treatment Admissions

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

Assessment and Treatment Process

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

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

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

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

Treatment Outcomes

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

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

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

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

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

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

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

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

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

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

Processes and Stages of Recovery

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

Recovery without Treatment/Moderated Recovery

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

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

Kurtz, in press).

Developmental Stages of Recovery

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

Recovery Support Structures

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

Substance Use and Partner Violence

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

Sentencing Issues

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

Tips for Enhancing Recovery among Women

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

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

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

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

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

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

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

- Best birthday you ever had
- Something you enjoy

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

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

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

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

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

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

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

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

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

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

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

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

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

Future Directions

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

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

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Appendices

Project SAFE A Developmental Model of Recovery

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

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

Recovery as a Developmental Process

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

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

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

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

The Core of Shared Experiences and Adaptations

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

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

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

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

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

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

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

Dependency as the Core Developmental Dimension for SAFE Women

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

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

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

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

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

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

The Limitations of Stage Theory

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

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

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

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

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

Stage 1: Toxic Dependencies

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

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

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

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

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

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

The etiology of the neglectful/abusive behavior exhibited by the SAFE client toward her children springs from multiple sources: the emotional deficits and debilities resulting from her own family of origin experiences, the lack of appropriate parenting skills, environmental chaos that competes with parenting responsibilities, increased loss of control over the drug relationship, and sustained exposure to a predatory drug culture. She constitutes the ultimate paradox of motherhood. Scorned and shamed by those who don't know her (How could a mother neglect her child because of a drug?), her desire to remain the mother of her children will remain the primary external force that sustains her through the change process.

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

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

Stage 2: Institutional Dependency

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

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

The Hope-Pain Matrix

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

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

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

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

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

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

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

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

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

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

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

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

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

Stage 3: Sisterhood

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

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

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

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

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

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

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

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

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

Stage 4: Selfhood and Self-help

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

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

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

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

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

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

Stage 5: Community Building

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

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

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

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

Stage 6: Interdependence

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

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

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

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