

# **Helping Women to Recover: Creating Gender-Specific Treatment for Substance-Abusing Women and Girls in Community Correctional Settings**

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Some of the most neglected and misunderstood women and girls in North America are those in the criminal justice system. Largely because of the “War on Drugs,” the rate of incarceration for women in the United States has tripled since 1980 (Bloom, Chesney-Lind, & Owen., 1994; Collins & Collins, 1996). Between 1986 and 1991, the number of women in state prisons for drug-related offenses increased by 432 percent (Phillips & Harm, 1998). Like their juvenile counterparts, most of these women are non-violent offenders who could be treated much more effectively and economically in community-based gender-specific programs.

When females are not a security risk, community-based sanctions offer benefits to society, to female offenders<sup>1</sup> themselves, and to their children. One survey compares an \$869 average annual cost for probation to \$14,363 for jail and \$17,794 for prison (Phillips & Harm, 1998). Community corrections disrupt females’ lives less than does incarceration and subject them to less isolation. Further, community corrections potentially disrupt the lives of children far less. Unfortunately, few drug treatment programs exist that address the needs of females, especially those with minor children. This is unfortunate because, when allied with probation, electronic monitoring, community service, and/or work release, community-based substance abuse treatment could be an effective alternative to the spiraling rates of recidivism and re-incarceration.

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<sup>1</sup> In this paper, the terms *female offender* and *female offending* will refer to females of all ages. *Delinquent* will describe only persons under eighteen years old. *Women offenders* will refer to persons over eighteen.

Historically, the differences between women and men have been overlooked, both in substance abuse treatment and in criminal justice policy. A growing body of research in North America indicates that substance abuse treatment programs that address women's and girls' unique needs, such as relationships with their partners, families, and children, and their history of physical and sexual abuse, are more effective (Carten, 1996; Center for Substance Abuse Treatment, 1994; Correctional Services of Canada, 1994; Covington, 1998; Finklestein & Piedade, 1993; Goldberg, 1995). Successful programs can be shaped by what has been learned since the 1970s about substance abuse and about women and girls in particular. Consequently, this paper addresses:

1. What is known about women and girls who enter our correctional systems;
2. What "gender-specific" services and substance abuse treatment are;
3. Three theoretical perspectives on addiction, female psychological development, and trauma that provide a foundation for a model of women's treatment;
4. The principles of an effective treatment program for women and girls in community corrections;
5. The use of Twelve Step mutual help programs.

### **Who Are the Women and Girls?**

In order to design a treatment program that matches female offenders' needs, it is important to consider who they are (i.e., the demographics and history of the female population) as well as how various life factors impact their substance abuse and patterns of offending. A basic principle of clinical work is to know who the client is and what she brings into the treatment setting. "[I]f programming is to be effective, it must . . . take the context of women's lives into account" (Abbott & Kerr, 1995). Therefore, a review of the literature on the lives of women and girls in the criminal justice system is presented.

Reliable and detailed data about females in community corrections programs is not collected annually in the U.S. or in Canada, although the U.S. national jail census does collect data every five years on women in local jails, and the U.S. Department of Justice's Bureau of Labor Statistics collects annual data on women housed in state and federal prisons. Consequently, most of the following discussion of female offenders is based on data about females who are in jail or prison in the U.S. and Canada (Austin, Bloom, & Donahue, 1992; Lightfoot & Lambert, 1992). Data about girls is even more difficult to obtain than data about adult women, because girls comprise a small percentage of the juvenile offender population. However, in general, female offenders can be said to differ from their male counterparts in several significant ways:

***Nonviolent Property and Status Offenses***

First, they are less likely to have committed violent offenses and more likely to have been convicted of crimes involving alcohol, other drugs, or property. Female offenders have been found to play a limited role in drug trafficking as “mules” (Phillips & Harm, 1998). Most of their drug convictions relate to using drugs. Many of their property crimes are economically driven, often motivated by poverty and/or the abuse of alcohol and other drugs. In a study of California inmates, 71.9 percent of women had been convicted on a drug or property charge, versus 49.7 percent of men. Men also commit nearly twice the violent crimes that women do (Bloom, Chesney-Lind, & Owen, 1994). These statistics are consistent with national trends in Australia, Canada, and the U.S. (Denborough, 1996; Lightfoot & Lambert, 1992; Steffenmeier & Allan, 1998).

Juvenile offenders also reflect this pattern in type of crime. Rates for less serious crimes, such as smoking marijuana and shoplifting, are similar for boys and girls. Rates of serious and violent crime are far lower among girls, although there is a perceived shift toward violent crimes (Belknap, 1996; Peters & Peters, 1998). Girls are more likely than boys to be arrested and detained for status offenses—acts that would not be offenses if committed by adults, such as promiscuity, truancy, or running away (Belknap, Dunn, & Holsinger, 1997; Pepi, 1998). Both promiscuity and running away are often connected to physical and sexual abuse in the home.

Of those females in prison for violent crimes, many of them committed their crimes against a spouse, ex-spouse, or boyfriend. They are likely to report having been physically or sexually abused, often by the person they assaulted. Thus, even violent female offenders are frequently not seen as at risk of committing violence against the general public (Browne, 1987; Denborough, 1996; Phillips & Harm, 1998).

***Substance Abuse Problems***

Substance abuse is a major problem for female offenders. In the U.S., “up to 80 percent of the women offenders in some state prison systems now have severe, long-standing substance abuse problems,” according to the Center for Substance Abuse Treatment (CSAT) (1997, p. 2). According to Snell (1994), drug violators make up 61 percent of women in U.S. federal prisons (up from 38 percent in 1986), 21 percent of the women in state facilities (up from 9 percent), and 23 percent of those in local jails (up from 9 percent). In Australia, 66 percent of women inmates have severe substance abuse problems (Consedine, 1995). More than 50 percent of U.S. and Canadian offenders (both male and female) self-report that alcohol or other drugs were involved in the crimes that led to their current imprisonment—and this figure is likely to be under the true proportion of substance-related crime (Brennan & Austin, 1997; Weekes, 1997). In a Canadian study (Lightfoot & Lambert, 1992), 25 percent of the women reported that their current incarceration was due to a drug offense, but almost 60 percent said they had used alcohol or other drugs on the day of the offense. Of that 60 percent, 59.6 percent said their substance use had seriously impaired their judgment. Yet despite the strong link

between substance abuse and crime, only a fraction of inmates receive treatment (Wellisch, Prendergast, & Anglin, 1994). For example, in California, only 3 percent of prisoners have access to any kind of treatment, even voluntary programs such as Alcoholics Anonymous (Bloom, et al., 1994).

To put these statistics into perspective, it is helpful to compare them to statistics on substance abuse of females in the general population. The Substance Abuse and Mental Health Services Administration (1993) reports that 2.1 percent of American females aged twelve and older had engaged in heavy alcohol use in the thirty days preceding the survey; 4.1 percent had used an illicit drug; and 1.2 percent had used a psychotherapeutic drug for a nonmedical purpose. By contrast, the National Center on Addiction and Substance Abuse (1998) found that 54 percent of women offenders in state prisons had used an illicit drug in the month prior to their crimes, and 48 percent were under the influence of either alcohol or another drug when they committed their crimes. Among women offenders in federal prisons, 27 percent had used an illicit drug in the month prior to their crimes, and 20 percent were under the influence when they committed their crimes. Among jail inmates, 54 percent had used an illicit drug in the previous month, and 48 percent were under the influence when they committed their crimes. It appears that substance-abusing females are present in U.S. jails and prisons by six to ten times more than in the general population.

In some U.S. states, these percentages are even higher. The Massachusetts Committee on Criminal Justice estimates that 90 percent of women prisoners have alcohol or drug problems (CSAT, 1997). In New Jersey, 85 percent of women offenders are in the criminal justice system for drug-related offenses (Gonzalez, 1996). The Bureau of Justice Statistics (1992) found that women are more likely than men to be under the influence of drugs when they commit their offenses.

The severity of female offenders' substance abuse problems varies. In one study of incarcerated women in Canada, 35 percent reported no drug-related problems, 29 percent showed low levels of alcohol or drug problems, and 36 percent were using alcohol or other drugs at moderate to severe levels (Lightfoot, 1997). Several U.S. states screen all offenders in their systems for alcohol and other drug problems: In Delaware, 25.6 percent of incarcerated women meet the screening criteria for long-term residential care, an additional 44.2 meet the criteria for short-term residential treatment, and 7 percent meet the criteria for intensive outpatient treatment. Only 9.3 percent of Delaware's women offenders need no treatment (Peyton, 1994). Similarly, of Illinois women inmates serving time for a class 2, 3, or 4 offense who report any drug dependence, 86 percent meet criteria for residential rehabilitation, 11 percent need intensive outpatient treatment, and an additional 3 percent need standard outpatient treatment (Illinois Criminal Justice State Plan, 1995). "The Illinois Department of Corrections finds that women enter prison at a more advanced and severe stage of drug abuse than men. Addicted women offenders therefore need longer treatment" (CSAT, 1997, p. 5).

***Psychiatric Disorders***

Substance abuse is the most common psychiatric disorder among female offenders. A survey of female pretrial jail detainees found that over 80 percent of the sample met the *Diagnostic and Statistical Manual of Mental Disorders* criteria for one or more lifetime psychiatric disorders (American Psychiatric Association, 1994). “The most common disorders were drug abuse or drug dependence (63.6%), alcohol abuse or alcohol dependence (32.3%), and PTSD [Post-traumatic Stress Disorder] (33.5%)” (Teplin, Abram, & McClelland, 1996, p. 508). Sixty percent of the subjects had exhibited drug or alcohol abuse or dependence within six months of the interview. In addition, 17 percent met the criteria for a major depressive episode. Subjects were mostly nonviolent offenders who had been jailed because they could not pay even the low bail for misdemeanors. This study concluded:

The American Bar Association recommends that persons with mental disorders who were arrested for misdemeanors be diverted to a mental health facility instead of arrested. With appropriate community programs, nonviolent felons also could be treated outside the jail after pretrial hearings. . . . Unfortunately, community-based programs are rarely available for released jail detainees, who often have complex diagnostic profiles and special treatment needs. (Teplin et al., 1996, p. 511)

Because Antisocial Personality Disorder (ASPD) is widely diagnosed among male offenders, treatment for offenders of both sexes often has focused on cognitive-behavioral approaches to treating it. However, ASPD is far less prevalent among female offenders than among males. In a Canadian study of opiate injectors, only 27 percent of the women met the full criteria for ASPD (Lightfoot, 1997). By contrast, depression, anxiety, and other mood disorders are far more common among substance-abusing females. In one study, major depression co-occurred with alcohol abuse in 19 percent of women (almost four times the rate for men); phobic disorder co-occurred in 31 percent of women (more than twice the rate for men); and panic disorder occurred in 7 percent of women (three and one-half times the rate for men). Furthermore, the rate of major depression among the alcoholic women was almost three times the rate in the general female population, and the rate for phobias was almost double. The rate of ASPD among alcoholic women was twelve times higher than the rate in the general female population. Still, only 10 percent of the alcoholic women were diagnosed with ASPD, far lower than the rates of depression and phobia (Blume, 1990).

The prevalence of dual diagnosis—females with both substance abuse and another psychiatric disorder—has not been well studied. However, in one study of both men and women, 23 percent of those surveyed reported a history of psychiatric disorders, and 30 percent of that group also reported having had a substance abuse problem at some time in their lives (Daly, Moss, & Campbell, 1993).

Dual diagnosis is complex and controversial. Women and girls in early recovery often show symptoms of mood disorders, but these can be temporary conditions associated with withdrawal. Also, it is difficult to know whether a psychiatric disorder existed in a given female before she began to abuse alcohol or other drugs, or whether the psychiatric problem emerged after the onset of substance abuse (Institute of Medicine, 1990). Research suggests that pre-existing disorders improve more slowly for the recovering substance abuser and need to be addressed directly in treatment.

### ***Poverty, Lack of Skills, and Ethnicity***

Furthermore, most female offenders are poor, undereducated, and unskilled. A survey of female jail inmates in the U.S. found that “over 60% were unemployed when arrested and one-third were not looking for work. Less than one-third of male inmates were similarly unemployed and less than 12% were not looking for work” (Collins & Collins, 1996). A Canadian study found that only 52.6 percent of the female offenders had completed secondary school. Most (43.8 percent) of the women in that study reported themselves as unskilled workers; another 10 percent said that their usual occupation was crime or homemaking (Lightfoot & Lambert, 1992). A U.S. study found that of those women who had been employed before incarceration, many were on the lower rungs of the economic ladder, with only 37 percent working at a “legitimate” job. Twenty-two percent were on some kind of public support, 16 percent made money from drug dealing, and 15 percent were involved in prostitution, shoplifting, or other illegal activities (Bloom et al., 1994).

A disproportionate number of female offenders are minorities. Arbour (1996) says Native women are over-represented in Canadian prisons. Bloom et al. (1994) found that over half of the women surveyed were African American (35 percent) and Hispanic (16.6 percent), one-third were Caucasian, and the remaining 13 percent were made up of other minorities. (See chapter by Chesney-Lind in this volume.)

### ***Single Motherhood***

Motherhood is also common among female offenders. Two-thirds of women incarcerated in the U.S. have children under the age of 18 (Bureau of Justice Statistics, 1991). A Canadian survey found that 62 percent of the women were parents, two-thirds of whom had custody of minor children at the time of the crime (Lightfoot & Lambert, 1992). Many of these women felt enormous guilt about being absent from their children’s lives and worried about whether they would retain custody of their children when they were released (Bloom & Steinhart, 1993; Watterson, 1996).

### ***Physical and Sexual Abuse***

Many women in prison also have a history of physical and sexual abuse. While it is estimated that 30 percent of females in the general Canadian population are sexually assaulted before age 18, over 50 percent of women in Canada’s Federal Prison for Women were sexually abused as children, and 75 percent were either physically or sexually

abused (Heney & Kristiansen, 1997). Eighty-two percent of the women offenders in another Canadian study reported histories of physical or sexual abuse (Task Force on Federally Sentenced Women, 1990). A U.S. study found that nearly 80 percent of female prisoners had experienced some form of abuse. Twenty-nine percent reported being physically abused as children and 60 percent as adults, usually by their partners. Thirty-one percent experienced sexual abuse as a child and 23 percent as adults; 40 percent reported emotional abuse as a child and 48 percent as an adult (Bloom et al., 1994). Another U.S. study found that 23 percent of female inmates had experienced incest or rape as juveniles; 22 percent had been sexually abused as adults; and 53 percent had been physically abused (Brennan & Austin, 1997).

Research on adolescent girl offenders reveals abuse histories that parallel those of adult women. For example, a study of girls involved in violent street crime in New York City found that almost all came from homes characterized by poverty, domestic violence, and substance abuse. Those who became delinquent as younger adolescents, as opposed to later in their teens, were more likely to have come from neighborhoods with “high concentrations of poverty,” to have been sexually or physically abused by a stranger, and to have friends involved in violent crime (Sommers & Baskin, 1994, p. 477). Sexual abuse victims, compared with nonvictims, begin drug use earlier and are more likely to be regular users of illicit drugs (Bodinger-de Uriarte & Austin, 1991).

### ***Girls Most at Risk for Substance Abuse***

Researchers once found a gap between rates of alcohol and drug use by girls and boys, but that gap is narrowing. Between 1991 and 1995, the rate of marijuana use within the past month among eighth-grade girls rose slightly faster than the rate for boys, reaching 8.2 percent for girls and 9.8 percent for boys. Past-month use of alcohol for girls reached 24 percent. Girls’ rates for inhalants and stimulants exceeded those of boys, and their rates of tobacco use were the same as boys’ (*Monitoring the Future Survey*, 1995).

Reasons for alcohol and other drug use among juveniles differs in some ways between girls and boys. For example, adolescent girls’ use of alcohol correlates more strongly with low self-esteem, stress, depression, and the desire to escape than does alcohol use among boys. While boys are more likely to be introduced to alcohol or marijuana by peers (other males), girls are more likely to be introduced not by peers (other females) but by boys, often in a party or dating situation. Hence, prevention programs that emphasize resisting peer pressure have shown much less effectiveness among girls than among boys (Bodinger-de Uriarte & Austin, 1991).

According to Bodinger-de Uriarte & Austin (1991), girls most at risk for use of alcohol and other drugs:

- began substance abuse early
- have parents, especially mothers, who abuse alcohol or other drugs

- are victims of sexual or physical abuse
- have weak family and school bonds
- have a poor self-concept, especially with regard to physical appearance
- have many opportunities to use drugs
- have difficulty coping with stress, especially with dating and sexual activity

### ***Adult Profiles***

Brennan and Austin (1997) characterize the “typical” female offender in U.S. prisons as:

probably minority, aged 25 to 29, unmarried, has one to three children, a likely victim of sexual abuse as a child, a victim of physical abuse, has current alcohol and drug abuse problems, multiple arrests, first arrested around age 15, a high school dropout, on welfare, has low skills, and has held mainly low-wage jobs (p. 3).

Community correctional settings reflect a similar population. For example, in the 100 community programs surveyed by Austin et al. (1992), most clients were African-American (50%) or Caucasian (37%) women between 25 and 30 years old, unmarried, and with children under age six. Program staff indicated that clients needed alcohol and drug treatment, domestic violence and sexual abuse counseling, employment, education, housing, and legal aid.

The Center for Substance Abuse Treatment (1997, p. 6) observes, “For the high proportion of women [offenders] with substance abuse problems, substance abuse acts as a multiplier for other problem areas, such as family problems, lack of economic self-sufficiency, physical and sexual abuse, and the inability to cope with caring for children.” This constellation of high-risk factors associated with relapse needs to be addressed in a comprehensive substance abuse treatment program.

### ***Pathways to Crime***

When the profile of girl offenders is compared to the profiles of adult women offenders, both in prison and in community corrections, it becomes clear that they are essentially the same females moving along the system from juvenile detention to jail or community corrections to state prison. Thus, two associations must be considered: the connection between childhood victimization and offending and the connection between substance abuse and offending.

Pre-feminist theories about pathways to crime have often claimed to be gender neutral, so separate data was not collected on women or girls or these data were omitted from various analyses. Research in the 1980s and 1990s reveals a pattern by which incest or other childhood victimization often leads girls (and some boys) to run away from home and/or to abuse alcohol or other drugs. Girls on the street then resort to prostitution, selling drugs, and/or robbery in order to survive. At any point in this process, a girl may be

arrested for running away or using alcohol (status offenses), using other drugs, dealing drugs, robbery, or prostitution (Arnold, 1990; Belknap & Holsinger, 1998).

Not only are rates of sexual abuse higher among substance abusers than among the general population, but rates of relapse from sobriety are higher among substance abusers with histories of victimization than among the non-victimized (Belknap & Holsinger, 1998). Female drug users are also more likely than males to report having been depressed before developing a drug problem. Females are less likely than males to use drugs for the “thrill” and more likely to use them to manage emotional pain.

The connection between substance abuse and offending is complex. As already stated, females may commit prostitution and property crimes in order to support drug habits or to survive economically. People working in corrections often consider the women’s substance abuse “just part of the generally deviant lifestyle characteristic of individuals with the propensity to antisocial behavior” (Lightfoot, 1997, p. 10). However, in the Canadian study of opiate injectors discussed earlier, 73 percent of the women lacked the full criteria for ASPD. In this case at least, substance abuse appears to have been their pathway to crime, not just a facet of their criminal behavior (Lightfoot, 1997). It would be interesting to know how many of the women with full criteria for ASPD were physically or sexually abused as children.

The desire for power also does not seem to be a primary pathway for female offending. The Canadian women studied by Sommers (1995) committed their crimes for reasons that included the desire for acceptance by others, an expression of the pain they had suffered at the hands of others, and an effort to maintain an adequate standard of living for their families. Relational and economic needs motivated them to commit crimes. These findings stand in stark contrast to theories of male criminality, such as social control theory (which links crime to weak social bonds and low belief in society’s rules) and power-control theory (which links crime to power dynamics in the home and workplace) (Belknap, 1996).

Daly (1992) found similar results in a study of U.S. court presentation investigation reports. Based on her research, Daly identified five pathways to female offending: (1) The *street woman*, who was severely abused as a child, lives on the street, and generally ends up in court because she has been supporting her drug habit through selling drugs, prostitution, and stealing; (2) The *harmed-and-harming woman*, who was also abused as a child, but who responded with anger and “acting out,” and who may have become violent through use of alcohol and/or other drugs; (3) The *battered woman*, who usually reaches court when she has harmed or killed a violent man with whom she is in or has just ended a relationship (unlike the previous two types of women, the battered woman usually does not have a previous criminal record); (4) The *drug-connected woman*, who “uses or sells drugs as a result of her relationships with her male intimate, children, or mother . . . like the battered women, she does not tend to have much of a criminal record”

(Belknap, 1996, p. 261); and (5) *Other women*, who commit economically motivated crimes, either out of greed or poverty.

### ***Conclusion***

In short, the females in the correctional system are mostly young, poor, and undereducated women and girls of color who have complex histories of trauma and substance abuse. Most are nonviolent and are not threats to the community. Survival (of abuse and poverty) and substance abuse are their most common pathways to crime (Chesney-Lind & Bloom, 1997). Their greatest needs are multifaceted treatment for alcohol and other drug abuse and trauma recovery, as well as education in job and parenting skills. They need the opportunity to grow, to learn, and to make changes in their lives.

### **Gender-Specific Services**

Based on this information about who female offenders are, what their pathways to crime are, and how they differ from male offenders, the need for a gender-specific substance abuse treatment program seems clear. But what exactly is a *gender-specific* program?

### ***Legislative and Judicial Declarations***

First, the U.S. Congress and courts have mandated equal access to services. The Equal Protection Clause of the Fourteenth Amendment of the U.S. Constitution requires that female offenders have access to the same quality and quantity of services that are provided for males (Collins & Collins, 1996). “Women have a constitutional right to equal protection regarding access and opportunities for education, vocational programs, rehabilitation, treatment, wages, and other privileges” (Brennan & Austin, p. 13). Litigation called “parity cases” has increasingly exposed the lower quality of services available to females. Gender-specific services should be developed to address this lack of parity.

In 1992, the U.S. Congress reauthorized the Juvenile Justice and Delinquency Prevention Act of 1974. This reauthorization “provided that each state should (1) conduct an analysis of the need for and assessment of existing treatment and services for delinquent girls, (2) develop a plan to provide needed gender-specific services for the prevention and treatment of juvenile delinquency, and (3) provide assurance that youth in the juvenile system are treated fairly regarding their mental, physical, and emotional capacities, as well as on the basis of their gender, race, and family income” (Belknap & Holsinger, 1998). This analysis is still underway in most states.

### ***Differences Between Males and Females***

Parity and fairness do not mean copying males’ programs and providing them to females. In order to be effective, such programs must meet the unique needs of females. In a 1997 report to the governor of Ohio on gender-specific services for adolescent girls, Belknap et al. (1997) wrote:

When examining gender-specific programming, it is important to recognize *equality does not mean “sameness.”* Equality is not about providing the same programs, treatment and opportunities for girls and boys. . . .

Equality is about providing opportunities that mean the same to each gender. This new definition legitimizes the differences between boys and girls. Programs for boys are more successful when they focus on rules and offer ways to advance within a structured environment, while *programs for girls are more successful when they focus on relationships* with other people and offer ways to master their lives while keeping these relationships intact. (p. 23, emphasis added)

All that we know about the differences between males and females needs be considered in the design of gender-specific program. For example, males engage in violent and aggressive behavior at five times the rate of females; women are more likely to attribute failure to their own incompetence; and women are more easily influenced by others, especially in contexts they perceive to be supportive (Garcia Coll, Miller, Fields, & Mathews, 1998).

At the same time, though, because gender differences have been used historically to justify inferior treatment for women and girls, feminist legal scholars still debate whether acknowledging differences reinforces the tendency toward sexist differences in programming and treatment. We must be sure that gender-specific services do not become sexist services (Belknap & Holsinger, 1998). For example, the argument that female offenders need less funding for services because they are less dangerous to society should be challenged as sexist, just as acknowledging females’ need for programs that address psychological trauma should not encourage a stereotype about women’s fragility.

### ***Most Promising Practices***

It is important to note that gender-specific correctional treatment programs have not been in existence long enough for there to be data on their long-term effectiveness. Descriptions of “most promising” practices given here are based on impressions of early data, as rigorous evaluations still need to be done (Austin et al., 1992).

With this caveat, Austin et al., (1992, p. 31) state, “The most promising approaches to community programs focus on the multidimensional problems of women offenders. These include gender-specific substance abuse treatment; parenting and family preservation; economic survival and life-skills training; sexual abuse and domestic violence counseling; and safe, affordable housing.” These conclusions are consistent with the conclusions of the Correctional Services of Canada report on substance abuse treatment (Lightfoot & Lambert, 1992) and their international review of model programs for women (Axon, 1989).

Bloom (1997, p. 3) states that the following criteria are necessary for gender-specific services for girls. The criteria are equally relevant for adult women:

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) defines gender-specific services as those that are designed to meet the unique needs of female offenders; that value the female perspective; that celebrate and honor the female experience; that respect and take into account female development; that empower girls and young women to reach their full human potential; and work to change established attitudes that prevent or discourage girls and young women from recognizing their potential.

Beckman (1994) recommends similar criteria for a gender-specific substance abuse treatment program:

- It is delivered in a setting compatible with females' interactional styles, such as their need for and responsiveness to social relationships
- It takes into account gender roles and female socialization
- It does not allow sexual harassment
- It supports active, interdependent roles for women and girls
- It addresses females' unique treatment issues, such as trauma, parenting skills, coping mechanisms, and self-worth

With regard to the value of community correctional settings, Bloom adds, "Whenever possible, women and girls should be treated in the least restrictive programming environment available. The level of security should depend on both treatment needs and concerns for public safety" (Bloom, 1997, pp. 4–5).

Stressing the importance of relational issues for girls, Belknap et al. (1997) recommend providing "the safety and comfort of same-gender environments," offering learning experiences after trusting relationships have been established, and helping girls to understand "that they can be professionally and emotionally successful in life and still have strong relationships" (Belknap et al., 1997, p. 24).

Issues of women's and girls' lives that gender-specific programs would address include, but are not limited to (Beckman, 1994; Belknap et al., 1997; Bloom, 1997):

- development of a sense of self and self-esteem
- establishment of trusting, growth-fostering relationships
- physical health
- sobriety—clean and sober living
- sexuality
- mental health
- physical fitness and athletics

- pregnancy and parenting skills
- decision-making skills
- trauma from physical, emotional, and sexual abuse—treatment and prevention
- cultural awareness and sensitivity
- spirituality

One example of a program designed to be gender specific is a pilot program in Canada's Federal Prison for Women. In that program, a Peer Support Team was created in which inmates with histories of physical or sexual abuse were trained to help other inmates cope with the effects of abuse. Team members were trained in socialization, homophobia, racism, classism, violence against women and children, substance abuse, women's anger, self-injury, suicide intervention, and counseling skills. Interviews with team members and those they counseled revealed that both groups were significantly helped by the peer counseling program (Pollack, 1993).

### ***Treatment Outcomes***

Treatment outcomes are also an important element of the definition of gender-specific substance abuse services. Schneider, Kviz, Isola, and Filstead (1995) recommend that abstinence not be the only way to measure the effect treatment has had on females' lives. They propose such additional outcome measures as consumption patterns, fluctuations in abstinence, number of days abstinent, amount of alcohol consumed post-treatment, and improvement in the following areas: physical symptoms, role performance, legal problems, and relationship and family problems.

Available data suggest that simply adding female-only services onto an existing mixed-gender program does not significantly improve female's lives post-treatment (Copeland, Hall, Didcott, & Biggs., 1993). Outcomes of truly gender-specific programs appear more promising. For example, Dahlgren and Willander (1989) compared Swedish women in a gender-specific treatment program to a control group of women in a traditional mixed-gender program. They found that women in the gender-specific program stayed in the program an average of eight months, while those in the traditional program stayed an average of five months. Thirty-five percent of the women in the gender-specific program reported improved relationships with their children, compared with 12 percent of the control group.

Similarly, Stevens and Arbiter (1995) studied a gender-specific therapeutic community for pregnant women, postpartum women, and women with children. They compared women who completed the program with those who dropped out and found that, six months after the end of the program, 64 percent of dropouts indicated alcohol or other drug use, as compared to only 31 percent of those who completed the program. More who completed the program were employed, fewer were receiving government assistance, and fewer had been rearrested.

A report by the National Association of State Alcohol and Drug Abuse Directors (NASADAD) details similarly positive results of treatment in thirteen states (Young, 1994). Examples of the data include reduced rates of subsequent arrest (Minnesota Chemical Dependency Division; Texas Commission on Alcohol and Drug Abuse); declines in criminal behavior, arrests, and jail time (Ohio Department of Alcohol and Drug Addiction Services); and reduced rates of criminal activity (California Department of Alcohol and Drug Programs).

Thus, the limited research on treatment outcomes shows a connection between treatment, reduced rates of relapse, and reduced rates of subsequent criminal activity and rearrest. Martin and Scarpitti (1993) found that women who relapse are seven times more likely to be rearrested as those who do not relapse. Therefore, treatment that reduces the likelihood of relapse will significantly affect rates of recidivism.

### ***System-Wide Considerations***

It is important to emphasize that a gender-specific program must take into account the entire system of a correctional facility. Glover-Reed observes, “Developing effective services for women cannot just consist of adding some additional components or providing staff training to existing programs. Although these actions are certainly necessary, they are not sufficient. The primary barriers to the provision of more women-oriented services are theoretical, administrative and structural, and also involve policy and funding decisions” (1987, p. 151; see also Glover-Reed chapter in this volume).

### **History of Treatment for Women and Girls**

The theoretical barriers to effective gender-specific services that Glover-Reed refers to become clear in light of the history of substance abuse treatment for women and girls. This historical context highlights what has and has not worked for females in the past.

### ***Alcoholics Anonymous and the Jellinek Curve***

In the past, substance abuse by women and girls was largely invisible because of the strong social taboos against women’s use of alcohol or other drugs. Men’s drinking problems were much discussed in the nineteenth and early twentieth centuries, but there was little talk about women’s drinking. In the United States, it was illegal to show a woman drinking in a movie or advertisement until the 1950s. This was not because women did not drink, but because people did not want to see women drinking. Even today, while it is more acceptable for a woman to drink or use recreational drugs, it is still not acceptable for them to be addicted. Families have far more denial about their sisters,’ mothers,’ and daughters’ substance abuse than about those of the men in the family.

Even after the advent of Alcoholics Anonymous in the 1930s, treatment programs and research focused on male alcoholics and addicts. Alcoholics Anonymous (AA) was highly effective for male alcoholics and became the standard for many kinds of mutual help recovery groups. Women and girls joined programs designed by men for men, and because

many females have recovered through AA, it has been difficult to question and discuss the contributions and limitations of AA for females' recovery.

The practical experience of AA became one of two cornerstones on which U.S. treatment programs were based. The second cornerstone was the research analysis of E. M. Jellinek, whose model of how people recover from substance abuse became known as the Jellinek curve. In 1945, *The AA Grapevine* mailed 1,600 questionnaires to recovering alcoholics, asking them to describe the process of their addiction and their recovery. Only 158 replies were received—a very poor response rate, even by the standards of statisticians at the time. Although Dr. Jellinek remarked on the data's questionable validity, he agreed to analyze and interpret it for AA. He found that the respondents diverged dramatically into two groups. Ninety-eight respondents described their addiction and recovery in one way, while fifteen described theirs in a very different way (the other 45 questionnaires were improperly filled out and could not be used). The larger group was all male, and the smaller group was female. Because the sample of fifteen women was too small to analyze separately, and because their data “differed so greatly” (Jellinek, 1946, p. 6), Jellinek threw out their responses and based his model on the men's data. No further investigation was made to see whether females indeed followed a distinct pattern of addiction and recovery or needed a distinct model for treatment. The Jellinek curve has been a cornerstone for treatment programs for fifty years and, like AA, it was based only on the experiences of men.

### ***The Women's Movement***

In the 1960s and 1970s, some women began to talk in consciousness-raising groups about previously taboo subjects: incest, rape, violence, and the use of alcohol and other drugs. In 1976, Congress responded to pressure from feminist organizations and alcohol and drug constituency groups with legislation that funded specialized women's treatment for the first time. Meanwhile, the National Council on Alcoholism created a special office on women. The programs launched by these initiatives laid the foundation for an understanding of treatment for women and girls (Galbraith, 1994). These programs demonstrated that females would seek and pursue treatment when it was “holistic” (addressing a broad range of needs, including sexuality, violence, and life-management skills), humanizing, long term, and child friendly—in short, when it was tailored for females. In the succeeding decades, clinicians and researchers have built on these initial findings and developed a solid body of knowledge in best practices for treatment of women and girls.

### ***Juvenile Programs***

Despite this growing information on best practices for treating females, male-based programming remains the norm in many settings. Even female-only programs are often merely copies of men's programs, not based on research or clinical experience with women and girls. This problem is especially acute for juveniles. Boys far outnumber girls in the juvenile justice system, so programs are designed with the needs of males in mind,

and services for female adolescents simply replicate the male model (Pepi, 1998). In a paper presented to the Australian Institute of Criminology, Tim Keough (1994, p. 3) wrote, “discrimination which affects young women who end up in custody is seen to be part of a broad systemic abuse based on gender. Through such systemic influences the system is seen to repeatedly fail to meet the needs of young women from abusive backgrounds.”

Currently, behavior modification is the counseling method of choice in almost 75 percent of juvenile institutions (Siegel & Senna, 1991). This method is often effective in the controlled setting of an institution, where the counselor can manipulate the situation, but it usually becomes ineffective when the adolescent returns to the outside world. Further, it fails to address girls’ history of physical, sexual, and emotional trauma.

Also, juvenile justice programs often reward girls for compliance and silence, even if that means suppressing their feelings and not voicing issues around abuse (Pepi, 1998). This approach conflicts with research that stresses the importance of girls regaining their “voice,” which is often lost in adolescence (Gilligan, 1991).

The Office of Juvenile Justice and Delinquency Prevention concludes, “Girls in juvenile justice need effective programs that do not perpetuate inequities based on gender, race, class, sexual orientation and other personal and cultural factors” (Girls Incorporated, 1996).

### ***Therapeutic Communities***

Among adult offender populations, a common model for treatment has been the therapeutic community. Chuck Dederich, an alcoholic and a former Gulf Oil executive, and his wife Betty, who wanted a more challenging and interactive approach to sobriety than AA provided founded Synanon in 1958. Dederich began hosting meetings with more discussion (cross-talk or responding to someone else’s story with feedback) which is discouraged in AA meetings. For economic reasons, recovering alcoholics began living together in what came to be called a “therapeutic community.” In that community, heroin addicts also entered recovery without medical intervention (Basic Interface, 1994).

In 1963, Dr. Dan Casriel founded DAYTOP and began to spread therapeutic communities throughout New York and Europe. Dr. Mitch Rosenthal founded Phoenix House in 1967; it continues to have more than a thousand residents in long-term care. The therapeutic-community model has been especially influential in correctional settings, where “modified therapeutic communities” are used frequently.

However, the confrontational approach traditionally used in therapeutic communities has not proven effective with the majority of women, as women require a different basis on which to build community: respect, mutuality, and compassion. An emphasis on assets and strengths, as opposed to tearing down the ego, has proven most effective with them.

### **A New Model for Treatment**

To summarize what has been stated so far, much is now known about who female offenders are, their pathways to crime, and the kinds of gender-specific services they need. Much is also known about the historic barriers to such gender-specific treatment. What is still needed is a treatment program for females that takes all of this information into account.

The author has developed a model for such a gender-specific treatment program in correctional settings based on research into the most promising practices identified in the past twenty years and on her own clinical experience. The program can be used in community correctional settings as well as in jails and prisons. Because many of the issues in the lives of women and girls in the criminal justice system are similar, the model is applicable to both.

Because experience and research have shown that an effective group program for females must deal with the issues specific to their recovery and create a safe and nurturing environment based on mutuality, respect, and compassion, the *Helping Women Recover* program was developed.<sup>1</sup> The program incorporates the guidelines for comprehensive treatment for women established by the U.S. government's Center for Substance Abuse Treatment (CSAT, 1994). It also reflects a theory-in-use model that integrates three theoretical perspectives: the theory of addiction, the theory of women's psychological development, and the theory of trauma. This program reflects the type of substance abuse treatment needed in correctional settings: one that is comprehensive and developmental and that integrates what is known about female recovery, both clinically and theoretically.

### **Theoretical Integration**

It is important to ground a gender-specific substance abuse program in theory—in the knowledge developed in the past twenty years about substance abuse and about women and girls, who often have histories of substance abuse since early adolescence; multiple trauma (including physical and/or sexual abuse, poverty, and racism); and developmental lags because of damaging relationships. The model presented here includes a theory of addiction, a theory of how women and girls grow and develop, and a theory of trauma.

### ***Definitions of Terms***

The terms *substance abuse*, *chemical dependency*, and *addiction* are often used interchangeably, and there has been criticism of their lack of specificity (Lightfoot, 1997). According to the *Diagnostic and Statistical Manual for Mental Disorders* (American

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<sup>1</sup> Covington, S. *Helping Women Recover: A Program for Treating Substance Abuse* (San Francisco: Jossey-Bass, 1999) is a special edition of the *Helping Women Recover* program. It is tailored especially for use in the criminal justice system. It is a complete program that includes both a facilitator's guide and a participant's journal.

Psychiatric Association, 1994), *abuse* is a recurrent pattern of pathological use that impairs social or occupational functioning. *Dependence* involves, in addition to abuse, increased tolerance or physical withdrawal symptoms. The distinction between physical dependence and psychological dependence is not always clear-cut. Further, most data on women and girls in the criminal justice system does not distinguish between substance abuse and chemical dependence (Lightfoot & Lambert, 1992; Teplin et al., 1996).

The criminal justice systems in both the U.S. and Canada do distinguish between alcohol and drug abuse/dependence. However, this distinction has to do with legal versus illegal substances, and not with treatment needs. Alcohol is a drug that happens to be legal. Few substance abusers use only one drug.

The model presented here is designed for both substance abusers and the chemically dependent. The theory of addiction used here is helpful regardless of where the female offender falls on the continuum from substance abuse to dependence. Clinical experience suggests that the length and intensity of treatment could vary for substance abusers and the chemically dependent, but that the issues they must work through will be the same. This model is applicable for both women and girls.

### ***The History of Addiction Theory***

For generations, societies saw addiction as a moral issue (Sandmaier, 1992). The use of alcohol or other drugs and the behavior of a person while using them were viewed as signs of lapsed morals. Under this moral model, relapse was attributed to a lack of will power or seen as a crime. The Temperance Movement and the U.S. “War on Drugs” reflect this model (Parks, 1997).

In the 1950s, mental health professionals proposed an alternative model in which addiction was seen as a sign of an underlying psychological disorder, such as a death wish, a fixation at the oral stage (as described by Freud), or a “sociopathic personality” (Brown, 1995, p. 13). If one could somehow solve the underlying disorder, then the addiction would go away. Any loss of control attributed to drinking or using other drugs was seen as temporary and secondary to the primary problem. It was believed that if a person drank excessively to cope with other difficulties then, if those difficulties were removed, she would go back to drinking in moderation.

During those same years, the chemical dependency field was born. Drawing on the work of AA and the Jellinek curve, practitioners outlined and advocated a model of addiction as a disease, where addiction was not a symptom but a primary condition with its own symptoms. Addiction became seen as a physical disease that carried no moral stigma. It was noted that addiction could not be managed through will power and required a lifestyle regimen for emotional and physical stability. Chemical dependency practitioners also saw that the disease of addiction included not just physical, but also emotional and spiritual dimensions.

In the 1990s, mental health and chemical dependency practitioners began coming together to learn from one another. At the same time, health professionals in many disciplines began to revise their concepts of disease in general. Based on a holistic health model of disease, many now acknowledge that all diseases include physical, psychological, emotional, and spiritual dimensions (Northrup, 1994) rooted in the individual, as well as environmental and sociopolitical aspects.

One way to describe addiction as a disease is to compare it with cancer. Both show large variations from one afflicted individual to another. Both have a physical dimension, one aspect of which is a genetic component. Studies have shown that rats left to themselves prefer water over alcohol, but that they can be trained to seek alcohol. Moreover, their descendants for four generations will seek alcohol *without training*. It is believed that alcohol has somehow changed their genetic material. In the same way, the tendency of addiction to run in families indicates a genetic component, just as a defective gene can cause certain types of cancer to run in families. Researchers have also found that a certain percentage of people actually metabolize alcohol differently from the rest of the population (Anthenelli & Schuckit, 1994).

Both addiction and cancer also have emotional and psychological dimensions. Stress and unhealthy ways of handling stress increase a person's risk of cancer, and, in the same way, they can increase the risk that one will turn to alcohol or other drugs. Alcohol use is also promoted by current social customs: advertisements use sex to sell alcohol, and alcohol is the drug of choice for seduction on college campuses (Kilbourne, 1991).

The socio-political aspects of cancer include the huge profits carcinogenic products make for powerful business interests. Similarly, companies that produce and sell alcohol are enormously profitable, even though they are indirectly responsible for over 23,000 deaths and three-quarters of a million injuries each year (Zawistowski, 1991). Medical doctors prescribe 80 percent of the amphetamines, 60 percent of the psychoactive drugs, and 71 percent of the antidepressants that women take (Galbraith, 1991). Few people question that cancer is a disease, even though as many as 80 percent of doctors link cancer to lifestyle choices (diet and exercise) and such things as pesticides, emissions, and nuclear waste in the environment (Siegel, 1996). Conversely, even though most medical and psychology professionals believe that addiction is a disease/disorder, politically it is still treated chiefly as a crime.

One reason why it is politically difficult to treat addiction as a disease rather than as a crime is that to view it as a disease requires acknowledging that the addict has lost control over an aspect of his or her life. The loss of control conflicts with one of Western culture's deepest beliefs: that the organizing principle of life is the individual's pursuit of power and control over self and others (Brown, 1995).

Professionals may continue to debate the merits of a disease model versus a disorder model, but the holistic disease model is a more helpful way to approach the treatment of females than is a disorder model. The disorder model focuses on social learning theory and a cognitive-behavioral approach to treatment (Parks, 1997). The main limitation of this approach is its focus on only one aspect of a multidimensional problem, ignoring the genetic studies, the affective aspects of both the problem and the solution (Brown, 1985), and the sociocultural and environmental issues. A holistic disease model allows clinicians to treat the addiction as the primary problem (not just a maladaptive means of coping with problems or a sequence of learned behaviors), while at the same time addressing dimensions of the disease, such as genetic predisposition, health consequences, shame, isolation, and/or a history of abuse.

Males and females show different patterns in substance abuse. Most family, twin, and adoptive studies have examined the link between substance abuse in fathers and sons, and the research clearly indicates a genetic link in men. However, women have been studied less in this respect. “Researchers often state that they chose male subjects because the effects of hormonal variations in female menstrual cycles could potentially affect the validity of the studies” (Finkelstein, Kennedy, Thomas, & Kearns, 1997, p. 7).

Environmental and psychosocial factors in females’ substance abuse have been much more thoroughly studied (Finkelstein et al., 1997). *Stigma*, or severe social disapproval, is the main psychosocial issue that has been found to distinguish females’ substance abuse from males’. While drinking-related behavior is often seen as “macho” in men, it conflicts with society’s view of femininity—especially with the roles of wife and mother. Women and girls often internalize this stigma. They may feel guilt and shame, and even despair and fear, as they find themselves unable to control their behavior. Mothers know they may lose their children if they fail in their recovery. Because the stigma is so shameful and potentially threatening to the family unit, females and their families may use denial to protect the status quo. Denial (minimizing the impact of substance use and abuse) by females and denial by their families are two major reasons why women and girls do not seek treatment.

In summary, the treatment model recommended here views chemical dependency as a disease, but from a holistic rather than a traditional (and limited) medical model. It is based on the belief that there are physical, psychological, emotional, spiritual, and even environmental and sociopolitical dimensions to the problem. Persons are not blamed for being addicted, but they are expected to resolve the problem with help from a variety of sources. Both the individual addict and the society that fosters addiction are addressed. This type of model is consistent with the public health model of disease in which the agent, the person, and the environment are all considered important factors. Chemical dependency can best be understood as a public health issue.

### ***The Spiral of Addiction and Recovery***

The generic definition of addiction used in this model is:

*A chronic neglect of self in favor of something or someone else.*

The process of addiction and recovery can be envisioned as a spiral. The downward spiral of addiction revolves around alcohol or other drug of choice. Addiction pulls the addict into ever tighter circles, constricting her life until she is completely focused on the drug. The addiction becomes the organizing principle of her life. Using alcohol and other drugs, protecting her supply, hiding her addiction from others, and cultivating her love-hate relationship with her drug come to dominate her world.

When a woman or girl is in this downward spiral, the counselor's task is to break through her denial. She comes to a point of transition, at which she must shift her perceptions in two ways: She must shift from believing, "I am in control" to admitting, "I am not in control" and she must stop believing, "I am not an addict," and admit, "I am an addict" (Brown, 1985, p. 34).

Both shifts in perception can feel humiliating. Our society inflicts far more shame on a female substance abuser than on a male, labeling her a "lush," "slut," "bad mother," and so on. While society may stigmatize a male addict as a bum, it rarely attacks his sexuality or his competence as a parent. It is necessary for a counselor to understand that a woman or girl who enters treatment may come with a heavy burden of shame. She should not be shamed further; rather, she should be offered the hope of recovery.

The upward spiral of recovery revolves around the drug in ever-widening circles, as the addiction loosens its grip and the female's focus moves away from the drug. Her world grows to include healthy relationships, an expanded self-concept, and a richer sexual and spiritual life. The process is not merely turning around and ascending the old downward spiral, but being transformed so that one ascends a different spiral. When women and girls speak of recovery, they speak of a fundamental transformation: "I'm not the same person. I'm different than I was."

### ***Female Psychological Development***

The definition given earlier of addiction raises several questions: How does a woman or girl shift from a chronic neglect of self to a healthy care of self? How does a female recover and grow? How can we facilitate and support this process?

Jean Baker Miller posed the question of how women and girls grow and develop in her 1976 book, *Toward a New Psychology of Women*. Traditional theories of psychology describe "development" as a climb from childlike dependence to mature *independence*, where the goal is to become a self-sufficient, clearly differentiated, autonomous self. In contrast, Miller said that a female's primary motivation is to build a sense of *connection with others*. According to Miller, a woman or girl develops a sense of self and self-worth

when her actions arise out of, and lead back into, connections with others—not from independence or separation.

Previously, theoreticians had treated women's emphasis on connection as a sign of deficiency. In her book, *In a Different Voice: Psychological Theory and Women's Development*, Carol Gilligan (1982) observed, "The disparity between women's experience and the representation of human development, noted throughout the psychological literature, has generally been seen to signify a problem in women's development. Instead, the failure of women to fit existing models of human growth may point to a problem in the representation, a limitation in the conception of the human condition, an omission of certain truths about life" (Gilligan, 1982, pp. 1–2).

Miller's work led a group of researchers and practitioners to create the Stone Center at Wellesley College for the purpose of thinking through the qualities of relationships that foster healthy growth in women (Jordan, 1984, 1985; Jordan & Surrey, 1986; Kaplan, 1984; Surrey, 1985). The basic assumption of the Stone Center model is that "connection" is a basic human need, and that this need is especially strong in women (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991). The model shows that all people need both connection with others and differentiation from others, but that females are more attuned to connection, while males are more attuned to differentiation. Byington (1997, p. 35) explained this connection as follows:

Theoretically, girls perceive themselves to be more similar than different to their earliest maternal caretakers, so they do not have to differentiate from their mothers in order to continue to develop their identities. This is in contrast to boys, who must develop an identity that is different from the mother's in order to continue their development. Thus, women's psychological growth and development occur through adding to rather than separating from relationships. Consequently, defining themselves as similar to others through relationships is fundamental to women's identities.

A "connection" in the Stone Center relational model is "an interaction that engenders a sense of being in tune with self and others, of being understood and valued" (Byington, 1997, p. 35). True connections are mutual, empathic, creative, energy-releasing, and empowering for all participants (Miller, 1986). Such connections are so crucial for women that women's psychological problems can be traced to disconnections or violations within relationships—whether in families, with personal acquaintances, or in society at large.

*Mutuality* means that each person in a relationship can represent her feelings, thoughts, and perceptions, and can both move with and be moved by the feelings, thoughts, and perceptions of the other person. Each person, as well as the relationship, can change and move forward because there is mutual influence and mutual responsiveness.

*Empathy* is a complex, highly developed ability to join with another at a cognitive and affective level without losing connection with one's own experience. An empathic person feels personally authentic in the relationship and feels that she can "see" and "know" the other person. A growth-fostering relationship requires mutual empathy, which in turn requires that both parties have the capacity to connect empathically. Empathy is also one of the five general principles underlying Motivational Counseling (Miller & Rollnick, 1991) and has been shown to be predictive of success in treating problem drinkers (Abbott & Kerr, 1995).

Mutuality and empathy empower women not with power *over* others but with power *with* others. Women feel more able to share power for constructive, creative ends. A gender-specific treatment program needs to follow such an empowerment model, allowing for mutual, empathic, and empowering relationships, producing five psychological outcomes: (1) increased zest and vitality, (2) empowerment to act, (3) knowledge of self and others, (4) a sense of self-worth, and (5) a desire for more connection (Miller, 1986). These outcomes have been shown to constitute psychological growth for women. Thus, mutuality, empathy, and power with others are essential qualities of a program both to foster growth in women and to help them recover from addiction.

Miller (1990) also described the outcomes of disconnections—non-mutual or abusive relationships—which she termed a "depressive spiral": (1) diminished zest or vitality, (2) disempowerment, (3) lack of clarity or confusion, (4) diminished self-worth, and (5) a turning away from relationships. All relationships involve disconnections, times when people feel their separateness and distance. However, growth-fostering relationships are able to allow disconnections that, with effort on each person's part, can be turned into connections. In non-mutual and/or abusive relationships, disconnections are not turned into true connections. Unfortunately, many women and girls have experienced such relationships and must overcome these effects.

Gilligan's work with adolescent girls reflects a developmental process similar to what Miller found in adult women. Gilligan discovered that, because of their desire for connection, girls aged ten to thirteen tend to give up their senses of self and their own voices in order to be in relationships with and acceptable to boys (Gilligan, 1982).

### ***Relationships and Substance Abuse***

From the perspective of the relational model, some women and girls use alcohol and other drugs in order to make or keep connections. Finkelstein (1993) suggests that treatment planners for substance-abusing females must take into account past family relationships, current relationships with family, friends, and partners, and relationships developed within the treatment context.

Disconnection and violation characterize the childhood experience of most women and girls in the prison system. According to a recent sampling of women in a Massachusetts prison (Garcia Coll & Duff, 1995), 38 percent of the women had lost parents in childhood, 69 percent had been abused as children, and 70 percent had left home before age 17. They lacked experience of mutual and empathic relationships. Although Gilligan, Lyons, & Hanmer (1990) report that girls are socialized to be more empathic than boys, female offenders have been exposed repeatedly to non-empathic relationships and so either lack empathy for both themselves and others or are highly empathic toward others but lack empathy for themselves. In order to change, women and girls must experience relationships that do not re-enact their histories of loss, neglect, and abuse.

In the same way, disconnection and violation have characterized most of the adult relationships of women in the prison system. Seventy percent of women in the Massachusetts study had been repeatedly abused verbally, physically, and/or sexually as adults (Garcia Coll & Duff, 1995). Another study, of drug-abusing pregnant women (Amaro & Hardy-Fanta, 1995, p. 333), found that “Men who go to jail, men who do not take care of them or their children, and men who disappoint them fill the lives of these women. Even more striking is the extent to which the women suffered physical abuse from their male partners. . . . Half of the women in this study reported abuse from the men in their lives; occasionally from ‘tricks,’ although more typically from their partners.” Robbery, beatings, and rape by men on the street were commonly reported. Women were often first introduced to drugs by partners, and partners often continued to be their suppliers. Attempts to stop using drugs and failure to supply partners with drugs through prostitution often elicited violence from partners. However, women remained attached to the men despite the neglect and abuse.

Another common form of disconnection women experience is isolation. Females at high risk for drug abuse are frequently socially isolated—single parents, unemployed, or recently separated, divorced, or widowed (Finkelstein, 1993; Finkelstein & Derman, 1991; Wilsnack, Wilsnack, & Klassen, 1986). Psychological isolation also occurs when the people in a woman’s world fail to validate and respond to her experience or her attempts at connection. Miller (1990) has described the state of “condemned isolation” in which a female feels isolated in her important relationships and feels that she is the problem; that she is condemned to be isolated. This state of self-blame and isolation is highly correlated with drug use, as drugs become a way of coping with intense feelings and a sense of hopelessness.

Shame is a third aspect of disconnection. Jordan et al. (1991) described the tremendous cultural shaming around females’ yearnings for connection, sexuality, and emotionality. Women and girls are prone to feel personally deficient (“something is wrong with me”), to take responsibility for problematic relationships, and to seek ways to alter themselves. In nonmutual relationships, females often carry the disavowed feelings of pain, anger, or fear

of those with whom they are connected. Women and girls in the criminal justice system endure more shame due to stigma from society.

Together, abuse, isolation, and shame can send women into the previously mentioned “depressive spiral”: (1) diminished zest or vitality, (2) disempowerment, (3) lack of clarity or increased confusion, (4) diminished self-worth, and (5) a turning away from relationships. This depressive spiral characterizes too well the females in our criminal justice system.

Connections and relationships are also involved in substance abuse in several other ways. First, addiction can be viewed as a type of relationship between the addict and the alcohol or other drugs, “a relationship characterized by obsession, compulsion, nonmutuality, and an imbalance of power. It is a kind of love relationship in which the object of addiction becomes the focus of a woman’s life” (Covington & Surrey, 1997, p. 338). Addicted women frequently use relational imagery to describe their drug use, such as “My most passionate affair was with cocaine.” At first the drug is her best friend, but as women describe the progress of their addiction, they say things like, “I turned to Valium, but then Valium turned on me.” Addiction may be thought of as a contracting of connections until there is only the relationship with the substance. Recovery, then, can be seen as an expansion of connection (Covington & Beckett, 1988).

Females frequently begin to use substances in a vain attempt to feel connected, energized, loved, or loving (Surrey, 1991). Women and girls often turn to alcohol or other drugs in the context of relationships with drug-abusing partners—to feel connected to the partner through the use of drugs. Partners are often their suppliers and often resist their efforts to stop using. Women and girls also use substances to numb the pain of nonmutual, nonempathic, even violent relationships.

Additionally, females may begin to use substances to alter themselves to fit the relationships available. Miller (1990) has described this basic paradox—when a woman cannot move a relationship toward mutuality, she begins to change herself to maintain the relationship. Stiver (1990) has written about children of “dysfunctional” families who frequently turn to substance abuse to alter themselves to adapt to the disconnections within the family, thus giving the illusion of being in relationships when they are not.

Healthy friendships are also challenging for females in the correctional setting. Prison is a difficult place in which to nurture trust. Yet, many women in prison do strive to create whatever level of relationships they can. Some build pseudo-families in which they relate like sisters, mothers, daughters, or lovers (Owen, 1998).

### ***Trauma Theory***

Because of the high rate of trauma in the lives of female substance abusers, a gender-specific treatment program for them also must take into account a theory of trauma. Roughly 1.8 million American women are abused each year. “While both male and female children are at risk for abuse, females continue to be at risk for interpersonal violence in their adolescence and adult lives. The risk for males to be abused in their teenage and adult relationships is far less than for females” (Covington & Surrey, 1997, p. 341).

A history of abuse drastically increases the likelihood that a female will abuse alcohol and other drugs. It also increases the likelihood of interaction with the criminal justice system. Alcoholic women are likely to have been abused sexually, physically, and emotionally by more perpetrators, more often, and for longer periods of time than their non-alcoholic counterparts (Covington & Kohen, 1984). Further, trauma is not limited to suffering violence; it includes witnessing violence as well as stigmatization because of race, poverty, incarceration, or sexual orientation. Thus, in treating a substance abuser, counselors must understand that they are also probably treating trauma survivors. Some women and girls who are considered “treatment failures” because they relapsed may be better understood as trauma survivors who returned to alcohol or other drugs in order to medicate their depression or anxiety, because they know no better ways to comfort themselves. Our increased understanding of trauma offers new treatment possibilities for substance-abusing trauma survivors (Barrett & Trepper, 1991; Lightfoot & Lambert, 1992).

The connection between substance abuse and interpersonal violence is threefold: (1) substance-abusing males are often violent toward women and children; (2) substance-abusing females are particularly vulnerable targets of violence; and (3) childhood abuse and current abuse increase a female’s risk of substance abuse (Miller 1991). Consequently, Canadian and U.S. researchers have agreed that any program for treating substance-abusing females must take into account that most clients will have suffered abuse (Correctional Services of Canada, 1994; Covington, 1998; Heney & Kristiansen, 1997).

Staff involved with a substance abuse treatment program need not be experts in trauma recovery, but it is helpful for them to understand the three stages of trauma recovery outlined by Herman (1992): safety, remembrance and mourning, and reconnection.

*Safety.* In particular, the design of the treatment program described here takes into account the needs of women at the first stage, safety, which is especially appropriate for a criminal justice setting. Safety is also emphasized in the “Substance Abuse Program for Federally Sentenced Women” developed for the Correctional Services of Canada (Abbott & Kerr, 1995). Women and girls must feel safe externally in a facility free of physical and sexual harassment and abuse. A treatment program can also help women feel safe internally by teaching them self-soothing techniques as alternatives to self-medication.

Sadly, for some women and girls, their first experience feeling safe is in a correctional setting. It is a harsh social reality that some females must be in an institution to feel safe. For other women and girls, their experience in the criminal justice system is traumatizing and triggers memories of earlier instances of abuse. It can be retraumatizing when a sexual abuse survivor has a body search or must shower with male guards nearby or if a battered woman is cursed at by a staff person. (The risk of such retraumatization is just one of the reasons why a community setting is preferable to prison for many offenders.)

*Behavior.* In addition to understanding the safety needs of abuse survivors, staff members operating a gender-specific treatment program need to understand how a history of abuse affects females' behavior. Survivors of sexual abuse often find that their sexual selves become "shaped in developmentally inappropriate and interpersonally dysfunctional ways" (Finkelhor & Browne, 1988, p. 69). A girl may grow up with misconceptions about morality, aggression, and sexual behavior. She may believe that her only value is her sexuality. "It is not surprising that survivors are more likely to become sex-trade workers" (Heney & Kristiansen, 1998, p. 31). Clearly, these females have an increased risk of entering the criminal justice system. Once in the system, they are often labeled "sexually provocative" and "sexually manipulative" without any acknowledgment of the sexual trauma that may underlie their behavior.

Survivors of abuse also can demonstrate symptoms of post-traumatic stress disorder (PTSD). Sexually abused children have unusually high rates of PTSD, especially those abused at a younger age (Wolfe, Gentile, & Wolfe., 1989). Teplin et al. (1996) found that 33.5 percent of pretrial jail detainees in their survey met the criteria for PTSD, and that this rate did not vary by ethnicity, education, or age. They suggested that this rate was slightly under-reported, as some subjects found their experiences of trauma too painful to discuss. Most of the PTSD cases were victims of rape or other violent assault.

*The Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994, pp. 427-429) lists the following symptoms of PTSD:

- Re-experiencing the event through nightmares and flashbacks
- Avoidance of stimuli associated with the event (for example, if a woman was assaulted by a blond man, she may fear and want to avoid men with blond hair)
- Estrangement (the inability to be emotionally close to others)
- Numbing of general responsiveness (feeling nothing most of the time)
- Hypervigilance (continually scanning one's environment for danger, whether physical or emotional)
- Exaggerated startle response (a tendency to jump at loud noises or unexpected touch)

Because PTSD can affect the way a woman or girl relates to staff, peers, and the environment of a correctional setting, it is helpful to ask, “Is this person’s behavior linked to PTSD?” A study of Australian female prisoners “demonstrated that PTSD and a history of abuse were almost ubiquitous in these women, and that these factors contributed significantly to their criminal histories” (McFarlane & Yehuda, 1996, p. 168).

Understanding PTSD and a history of abuse is especially important with regard to females diagnosed with Borderline Personality Disorder (BPD), a diagnosis too often used for women and girls whose behaviors stem from their efforts to survive horribly traumatic experiences (Root, 1992).

*Relational Development.* Third, a gender-specific treatment program need to address the ways in which trauma affects a female’s relational development:

Women recovering from childhood molestation, rape, or battering are teaching us about the impact of such trauma on relational development. When early parental relationships are abusive, violating, and dangerous, all future relationships are impacted. The very high rate of substance abuse and addiction among survivors of abuse and violence suggests the likelihood of turning to substance abuse when healthy relationships are unavailable and when faith or trust in the possibility of growth in human connection is impaired. The use of alcohol and other drugs has become a way for women to deal with the emotional pain resulting from earlier abuse by someone close to them, someone they trusted. (Covington & Surrey, 1997, p. 342)

*Societal Context.* Finally, personal violence toward women and girls must be understood in the larger societal context of systemic violence and oppression, including racism, classism, heterosexism, and ageism.

### ***Integration of Theoretical Frameworks***

Three theoretical perspectives—addiction, women’s development, and trauma—have been briefly described thus far. In the past, women and girls often have been expected to seek help for addiction, psychological disorders, and trauma from *separate sources* and to incorporate what they learned from a recovery group, a counselor, and a psychologist into their own lives. This expectation has placed an unnecessary burden on recovering females. A gender-specific treatment program needs to integrate all three approaches for the clients in order to increase their potential for recovery.

## **Structure and Content of an Effective Treatment Program**

Both structure and content should be considered when designing a gender-specific treatment program for substance-abusing women and girls. Not just the content of the program, but also the context/environment is important. The program needs to have the following qualities:

### ***A Supportive Environment***

An environment that supports recovery is characterized by the following:

- *Safety*: The environment is free of physical, emotional, and sexual harassment and spoken and unspoken rules of conduct provide appropriate boundaries. Although it may be impossible for a staff member to guarantee safety in her agency or institution, it is imperative that the treatment group itself be a safe place.
- *Connection*: Exchanges among the treatment group facilitator and group members need to feel mutual rather than one-way and authoritarian. Females begin to heal when they sense that a group facilitator wants to understand their experiences, is present with them when they recall painful experiences, allows their stories to affect her, and is not overwhelmed by their stories.
- *Empowerment*: The facilitator needs to model how a woman or girl can use power with and for others, rather than either using power over others or being powerless. It is important to set firm, respectful, and empathic limits and to encourage the group members to believe in and exercise their abilities.

Some people question whether a healing environment can be created in a correctional setting. There can often be a clash between the “control” model of corrections and the “change” model of substance abuse treatment. Hence, a correctional setting is rarely therapeutic. However, even within correctional institutions, healing spaces can be found (Boudin, 1998). It is important for the group facilitator to encourage women to struggle with the conditions of the correctional setting and continue to thrive. Recovery can happen in or out of a correctional setting. In fact, for some women, prison offers their only chance of residential treatment.

### ***Psychoeducational Model***

Using a psychoeducational model, the facilitator educates women and girls in treatment programs about abuse and violence, about how society socializes women, and so on. In this way females are enabled to interact both cognitively and emotionally with the content, which is crucial to their learning.

Cognitive models have become popular in criminal justice settings. However, the available research does not support these models for females, whose treatment needs to be based on the premise of the whole person, emphasizing affective, cognitive, and behavioral change. The affective aspect is especially important for women and girls because their substance-abusing behavior must be understood in the context of their emotional lives.

Miller and Stiver (1997, p. 212) believe that:

This separation of thought and feeling seems clearly linked to a long-standing gender division in Western culture. Thinking has been linked with men and is the valued capacity; feeling has been linked with women and is disparaged. In contrast, we believe that all thoughts are accompanied by emotions and all emotions have thought content. Attempting to focus on one to the neglect of the other diminishes people's ability to understand and act on their experiences.

Instead of dealing with thoughts and feelings as separate entities, Miller and Stiver propose dealing with them as “thought-feelings” or “feeling-thoughts” (p. 27). This is an appropriate concept to incorporate into women's treatment programs.

### ***Three Levels of Intervention***

The group process and individual exercises used need to help women and girls on three levels: cognitive, affective, and behavioral.

At the *cognitive* level, education can help to correct their misperceptions and distorted thinking. They can learn a process of critical thinking for decision making. In the *Helping Women Recover* program (Covington, 1999), for example, females practice the ORID process (Spencer, 1989) of interpreting and responding to an experience. This process includes four stages:

- *Objective*: Obtaining facts through observation
- *Reflective*: Expressing emotional reactions to the event or experience
- *Interpretive*: Assessing the meaning and impact of the event, its significance or usefulness, and its value
- *Decisive*: Identifying actions or decisions in response to the experience

The *affective* level is an especially important component for a female treatment program. The absence of feeling or reduced feeling is common in early sobriety (Brown, 1985) and affect emerges as recovery progresses. Females need to learn to express their feelings appropriately, as well as to contain them in healthy ways through self-soothing techniques. Because females frequently become dependent on drugs in order to seek relief from painful emotional states, they require an environment during recovery in which to understand their feelings and work through their emotions. Because females are often raised to suppress their feelings and to be compliant, if a treatment program obliges them

to act in the same way, it can feel like the original abusive environment in which they learned to keep silent and turn to alcohol or other drugs. Such silence encourages them to avoid dealing with issues that can lead to relapse (Pepi, 1998). As feelings emerge in early recovery, females may feel confused and return to a cognitive focus on their drug of choice unless they have a context in which to learn new ways of handling those feelings.

Goleman's work on emotional intelligence emphasizes the importance of emotional development and its connection to juvenile delinquency and substance abuse. He says that a "craving for calm seems to be an emotional marker of a genetic susceptibility to alcoholism," and that "a second emotional pathway to alcoholism comes from a high level of agitation, impulsivity, and boredom" (Goleman, 1995, p. 254). He further notes a study associating opioid addiction with a lifelong difficulty in handling anger. Such research implies that helping women and girls handle feelings such as anger, agitation, and depression may decrease rates of relapse.

Art therapy is one potential treatment modality for helping females with emotional development. Merriam (1998) describes the benefits of art therapy for trauma survivors in a Canadian prison. It helped the women and girls lower their defenses, decrease anxiety, and gain insight into information that they had denied or dissociated. Art therapy can help to give females a voice when they are unable to verbalize their emotions or experiences.

Finally, a gender-specific treatment program needs a *behavioral* component. Women and girls must make changes in their drinking or drug-using behavior. For addicted females, the goal is abstinence. For the non-addicted, success may be evaluated by increased levels of functioning in every aspect of their lives.

### ***Asset Model***

In a traditional model of treatment, the therapist does a needs assessment and focuses on what is missing or what is "wrong" with the client. The drawback of this model is that the women and girls already are struggling with poor self-perceptions because of the stigmas attached to their substance abuse, their prison records, their parenting histories, and so on. In contrast, an asset model of treatment empowers each woman or girl and increases her sense of self.

Using an asset model, the facilitator helps the treatment group members to see the strengths and skills they already have that will aid their healing. She helps them to look to "the seeds of health and strength" within their symptoms. For example, the facilitator portrays a female's relational difficulties as "efforts to connect," rather than as "failures to separate or to disconnect." The facilitator repeatedly affirms the females' abilities to care, empathize, use their intuition, and build relationships. "As a woman feels more valued, her need for alcohol, tobacco, and other drugs might diminish and her resilience increase" (Finkelstein et al., 1997, p. 6).

The following is an excerpt from a strengths and needs assessment tool developed by Fedele and Miller (1988, pp. 17–18):

The need to state clearly how I feel

\_\_\_\_\_

0    1    2    3    4

The strength to express my feelings in my relationships with others

\_\_\_\_\_

0    1    2    3    4

The need to express my anger appropriately

\_\_\_\_\_

0    1    2    3    4

The strength to express my anger appropriately

\_\_\_\_\_

0    1    2    3    4

The need to take appropriate action to express myself under stress

\_\_\_\_\_

0    1    2    3    4

The strength to take appropriate action to solve problems

\_\_\_\_\_

0    1    2    3    4

The need to address my own substance abuse

---

0    1    2    3    4

The strength to find effective ways of coping with stress

---

0    1    2    3    4

The need to address the substance abuse of a loved one

---

0    1    2    3    4

The strength to recognize the substance abuse of a loved one

---

0    1    2    3    4

It is important to realize that just as women's lives are different from men's lives, women's lives are not all the same. Although there are common threads in all women's lives because of their gender, it is important to be sensitive to cultural and other differences. For example, there are differences in the lives of African-American women, Hispanic women, and Asian women. There are differences between heterosexual women, bisexual women, lesbian women, and transgendered women. There are differences between older women and younger women. The facilitator must remain aware of and sensitive to the issues of diversity in the group.

### ***Single-Gender Groups***

Research suggests that although men may benefit from mixed-gender groups, women benefit more from all-female groups (Aries, 1976). In all-male groups, men say little about themselves, their key relationships, or their feelings. In all-female groups, women share a great deal about themselves, their feelings, and their relationships with lovers, friends, and family. In mixed groups, men reveal much more about themselves and their feelings, while women reveal much less (Priyadarsini, 1986).

According to Aries, the amount of sharing differs as much as the content. In all-female groups, women strive to equalize the amount of time each woman talks—they draw one another out, fall silent after long speeches, speak up more after an absence or long silence, and avoid dominating the conversation. However, in mixed groups women tend to yield the floor to men; women may take up only one-third of the time, even though they make up half of the group. Additionally, men often punish women who fail to yield to them.

Women and girls are much more supportive of one another in all-female groups than in mixed groups. Women and girls are often socialized to compete for male attention when males are around, yet will cooperate with one another when males are not.

Aries found that, over time, women placed in both mixed and single-gender groups expressed a preference for the single-gender groups, while men over time preferred the mixed groups. These preferences make sense, given that mixed groups tended to expand the men's styles of relating while restricting the women's styles.

Aries studied high-functioning young men and women who were conversing about relatively nonthreatening topics. Women and girls who lack secure senses of self and have histories of abuse by males are even less likely to speak up on taboo topics, such as addiction, sexual abuse, and violence, when males are present. Consequently, single-gender groups are essential for females.

Sometimes females say they do not want to be in a female-only group and that they get along better with males. Women and girls who say this usually get along with males by relying on stereotypical female behavior, rather than by expressing their true selves. Also, females are more able to hide parts of themselves in a mixed group. In an all-female group, females tend to challenge one another's pretenses and denial; in a mixed group, females let one another get away with more because they understand the pressure to look good in front of males.

When a female says, "I don't like women" or "I don't like girls," she is also saying, "I don't like myself." Such a female can benefit greatly from learning to trust and respect other females—and her own femaleness—in an environment in which there is no pressure to compete for male attention.

There is some debate among clinicians as to whether female-only groups are preferable for all women. In their review of the literature, McWilliams and Stein (1987) found that single-gender groups were the treatment of choice for certain clinical groups, including sexual abuse survivors and battered wives or lovers. Herman (1992) also emphasized that a trauma survivor who is working on Stage-One recovery—safety—needs to be in a homogeneous recovery group. It is often difficult for females to talk in depth about physical or sexual abuse in front of males until they are ready for Stage-Three recovery—reconnection. Graham and Linehan (1987) found female-only groups to be preferable in dealing with chronic alcoholism. Bernardez (1978 & 1983) pointed out that single-gender groups helped females develop assertiveness, redefine their understanding of feminine behavior, experiment with the balance between their own needs and those of others, and identify positively with other females. On the other hand, Alonso (1987) said that mixed-gender groups offer females more alternatives to hyperfeminine personality traits and better represent the real world females live in. In assessing Alonso's views, Fedele and Harrington (1990) concluded that single- and mixed-gender groups are appropriate for females at different stages of their lives. When a female is at a stage of needing to consolidate experiences, ideas, feelings, and a sense of self (as in early substance abuse recovery), a single-gender group is preferable. Once her experience has been validated, she

has more empathy for herself, and she is more empowered (as in later recovery) a mixed group may be appropriate for the next stage of her development.

Thus, while mixed groups may have their place in later recovery, it is important that a gender-specific treatment program for early substance abuse recovery use single-gender groups. Treatment group facilitators also must be female.

#### ***Four Content Areas***

In the context described above, women and girls can effectively deal with the content of a gender-specific treatment program. The Center for Substance Abuse Treatment (CSAT, 1994) has stated the following content issues that are essential to address in a comprehensive treatment program:

1. The process of addiction, especially gender-specific issues related to addiction (including social, physiological, and psychological consequences of addiction, and factors related to the onset of addiction)
2. Low self-esteem
3. Race, ethnicity, and cultural issues
4. Gender discrimination and harassment
5. Disability-related issues, such as transportation and employment, where relevant
6. Relationships with family and significant others
7. Attachments to unhealthy interpersonal relationships
8. Interpersonal violence, including incest, rape, battering, and other abuse
9. Eating disorders
10. Sexuality, including sexual functioning and sexual orientation
11. Parenting
12. Grief related to the loss of alcohol or other drugs, children, family members, or partners
13. Work
14. Appearance and overall health and hygiene
15. Isolation related to a lack of support systems (which may or may not include family members and/or partners) and other resources
16. Life plan development
17. Child care and custody

Rather than seeing these issues as “problems” that a woman and her support system need to “solve,” it is more helpful to use the CSAT list to assess the “level of burden” a woman or girl carries (Brown, Huba, & Melchior, 1995, p. 340). This approach avoids adding to the stigma that females feel because of their problems; it helps counselors understand how to respond when a female does not comply with treatment; and it equips counselors to educate other staff members and family members.

The CSAT list takes into account physical, psychological, emotional, spiritual, and sociopolitical issues of substance abuse. These seventeen issues may be grouped into four major areas: self, relationships, sexuality, and spirituality. Interviews with women in recovery indicate that these four areas cover the major aspects of life that change during recovery and that are the most common triggers for relapse if not addressed (Covington, 1994). The author's model for a gender-specific program addresses these four areas in four separate modules. The topics covered in each module are sequenced developmentally from least to most sensitive:

- *Self*: In this module, the females discover what the “self” is; learn about the sources of self-esteem; consider the effects of sexism, racism, and stigma on a sense of self; and begin to develop their own senses of themselves. Substance abuse can be understood as a “self-disorder” (a generic definition of addiction is “the chronic neglect of self in favor of something or someone else”). Therefore, one of the first questions women and girls in recovery need to begin to address is, “Who am I?” Females in our culture are taught to identify themselves according to role: mother, professional, wife, partner, daughter. Those in the criminal justice system also identify themselves—as does society—as offenders, and they become stigmatized. Further, many females also enter the system with poor self-images and a history of trauma and abuse. Creating the kinds of programs that help women and girls to develop a strong sense of themselves, an identification that goes beyond who they are in the criminal justice system, is vital to their re-entering society. Recovery is about the expansion and growth of the self. This module enables women and girls to integrate their outer selves (their roles) with their inner selves (their feelings, thoughts, and attitudes).
- *Relationships*: In this module, the women and/or girls explore their roles in their families of origin; discuss myths about motherhood and their relationships with their own mothers; look back on their relationship histories, including possible histories of interpersonal violence; and make decisions about how they can build healthy support systems. Relationship issues are paramount in early recovery. Some females use addictive substances to maintain relationships with drug-using partners, to fill a void in the relationship, or to deal with the pain of being abused. Those in the criminal justice system often have unhealthy, illusory, or unequal relationships with spouses, partners, friends, and family members. For that reason, it is important for programs to model healthy relationships among both staff and participants and to provide a safe place for healing. Being in a community—that is, having a sense of connection with others—is essential for continuous, long-term recovery.

- *Sexuality*: In this module, the females explore the connections between addiction and sexuality, body image, sexual identity, sexual abuse, and the fear of sex when clean and sober. Sexuality is a neglected area in substance abuse treatment, and it is a major cause of relapse (Covington, 1997). Healthy sexuality is essential to a woman's sense of self-worth. Because substance abuse often interrupts the normal process of a woman or girl's healthy sexual development, she may enter recovery with developmental lags. Many females begin recovery struggling with sexual dysfunction, shame, fear, and/or trauma that need to be addressed so that they do not return to using alcohol or other drugs to manage the pain of these difficulties.
- *Spirituality*: In this module, the women and girls are introduced to the concepts of spirituality, prayer, and meditation, and asked to consider how these can contribute to their recovery. They also create a vision for their immediate future in recovery. Reconnecting to her own definition of spirituality is essential to a female's recovery process. Spirituality deals with transformation, connection, meaning, and wholeness, (Covington, 1998a)—all factors in recovery.

### **Twelve Step Programs and Females**

The type of gender-specific treatment program described above can be paired effectively with Twelve Step programs such as Alcoholics Anonymous (AA). Many people think of Twelve Step programs as being only in the U.S. However, in 1990, AA had an estimated two million members in over 80,000 groups around the world. There are also at least 126 other kinds of Twelve Step groups, such as Narcotics Anonymous and Cocaine Anonymous, for persons who have other dependencies and for the families of such persons (Alcoholics Anonymous World Services, 1992). The percentages of females in AA groups “range from 10 percent in Mexico to 44 percent in Austria and up to 50 percent in Switzerland” (Makela et al., 1996, p. 170). AA boards in Finland, Mexico, and the United States have held national working groups on women's issues. In fact, there are more women in AA than in professional treatment (Makela et al., 1996).

A 1996 survey by the National Center on Addiction and Substance Abuse (1998) found that 74 percent of prison facilities offer mutual help groups, mostly Alcoholics Anonymous, Narcotics Anonymous, or Rational Recovery. Most local jails also offer groups modeled on AA or NA. The sheer availability and familiarity of these programs makes them a useful adjunct to a gender-specific treatment program.

Mutual help groups such as AA are free, and because of their sheer numbers they are readily available in most urban areas. People are allowed to come and go without signing a contract or having a record kept of their presence. Meetings are consistent in their format, so that a person can drop in on a new group and have confidence that the guidelines that make AA work will be adhered to. Female-only meetings are widely available. In addition,

AA provides a bridge back into the community for women leaving jails and prisons. The meetings create a different kind of community from that available in institutions and can expand females' sense of what support is possible. AA also provides a different kind of community from what is available in a community correctional facility. The Twelve Step option is especially important in a time when money for substance abuse treatment and psychological services is limited (Covington, 1991).

In recent years, Twelve Step programs have been critiqued in various ways. Some feminists have been concerned that the language of the Twelve Steps seems simplistic, sexist, and reductionist (Bepko, 1991; Berenson, 1991; Kasl, 1992; Rapping, 1996). Certainly AA has limitations. It stresses individual change as the solution and ignores social and political factors that hinder female sobriety, such as the systems of domination in which women live. Also, much of the AA literature is twenty to fifty years old and is overtly sexist. Atheistic, humanistic, and agnostic women may be uncomfortable with AA's references to a "Higher Power," even though AA welcomes a broad range of understandings of the Higher Power, including "Goddess," "Buddha," and a "Deeper Self."

Other mutual-help groups have been formed in recent years to address these limitations. Women for Sobriety groups resemble feminist consciousness-raising groups. Save Our Selves groups follow a format similar to AA's but omit references to a Higher Power in any form.

References to powerlessness in the first of AA's Twelve Steps also concern many critics. They say that to ask women and girls to admit their powerlessness over alcohol and then over persons, places, and things is to encourage the women and girls to think of themselves as victims who have no control over their lives. However, this critique misses the paradox of powerlessness: by admitting her powerlessness over alcohol, a female accesses areas of her life in which she does have power. For example, by admitting her powerlessness to change someone with whom she has relationship, she is empowered to make decisions about how to relate to that person. Despite the sexist language, women and girls are generally able to interpret the Twelve Steps in ways that are personally meaningful and useful.

Feminists, in particular, are concerned about the Twelve Steps' emphasis on powerlessness as liberating. In contrasting the recovery movement with the women's movement, Walters (1990) points out that "one movement encourages individuals to surrender to a spiritual higher power, where the other encourages people to join together to challenge and restructure power arrangements in the larger society" (p. 55).

However, feminist analysis often misses the fact that the masculine "power over" is being relinquished in order to experience the feminine "power with," "power to be able"—that is, a sense of empowerment (Miller, 1982). "The process of recovery from addiction is a

process of recovering a different, more feminine, sense of power and will” (Berenson, 1991, p. 74). There is also a confusion between surrender and submission. “When we submit, we give in to a force that’s trying to control us. When we surrender, we let go of our need to control” (Covington, 1994, p.48). Recovery encourages surrender and giving up the illusion of control.

French (1985) writes that “life is the highest value for ‘feminine’ people; whereas control is the highest value for ‘masculine’ people” (p. 93). As previously noted, Brown (1995) observes that control—the power of the individual over self and others—is the organizing principle of life in Western culture. Moreover, this Western belief in the importance of power and control is one of the foundations of the criminal justice system. Hence, it is not surprising that powerlessness would be an alien and devalued concept in Western culture, especially in criminal justice settings.

If addiction reflects a lack of self-control, then the natural Western goal is to regain control so that one can continue to use alcohol or another drug in a “controlled” manner. If chemical dependency is a learned behavior, then it can presumably be unlearned through behavioral means and the individual returned to a state of self-control. However, if chemical dependency is a disease, irreversible and incurable, then self-control over the disease is not possible. In this case, the individual must learn to acknowledge her lack of control and pursue a process that involves affective, cognitive, and behavioral changes with a goal of abstinence.

At the root of the ongoing controversy over the best treatment for substance abuse are two polar views of AA. Some professionals are strongly in favor of a chemical dependency framework that incorporates Twelve-Step work, while other members of the mental health field are often skeptical of such a framework. Treatment from a traditional mental health perspective usually focuses on only one approach—behavioral, cognitive, or psychodynamic—whereas an integration of all three is needed to treat this multi-dimensional disease. In a similar way, when chemical dependency treatment ignores the the multiplicity of issues, it too fails to address females’ needs fully. AA integrates behavioral, cognitive, psychodynamic, and systems treatment models, as well as addressing spiritual issues. Women and girls require this kind of comprehensive, integrated, developmental model. If addiction is seen as a disease that manifests in many different ways in different women, the need for multiple strategies is clear.

Because females grow and develop in relationships and connections, and because Twelve Step programs are free and available in our communities, it makes sense to enable females to have access to them, both while in the criminal justice system and while making the transition back into the community. Twelve Step programs also can be incorporated into community correctional settings, offering an already-existing “continuity of care.”

Mutual-help groups cannot be used as substitutes for professional counseling when a female has been raped or battered or is the victim of incest. However, as part of a multifaceted support system, mutual-help groups can be very useful for women and girls in recovery. They provide the kind of safe environment that is needed for trauma recovery and a growth-fostering relational context that serves females' psychological development.

### **Women's Voices**

Substance-abusing women themselves are a valuable resource for educating those of us in the free world. If we are willing to listen, they will tell us who they are, what they need, and what can make a difference in their lives. The following descriptions are excerpts from letters written by women at the Atwood Treatment Program (1994) when the U.S. Federal Prison in Lexington, Kentucky, housed women<sup>1</sup>:

My name is Mary. I have been incarcerated for about 15 months of a 70 month sentence. My crime is "Conspiracy to Manufacture Methamphetamine." I am a heroin addict, a speed addict, and a drug manufacturer. I've been in and out of my addiction since my early 20's. I am currently 47 years old. I have about equal time clean & straight and active addiction.

My name is Brenda. I am 37 years old and have 3 children. I was in a very emotional and physical abusive relationship for almost 20 years up until the time I was incarcerated.

Hello my name is Dorothy. . . . I'm thirty-one years old and have been in and out of jails and institutions since I was thirteen years old. All of my incarcerations have been a direct result from my behavior while using drugs and alcohol.

My name is Janet, I'm here in prison on a drug charge. I've been in my active addiction since I was seventeen. I'm now thirty-four years old. My idea of a relationship with a man consisted of doing whatever I was told for the last ten years. Like prostitution, robbery, and a little bit of everything short of murder. Seven of the years he has been locked up and he loved me so I couldn't leave him. When I caught my case and was coming to prison I had nothing to offer him so he dropped me.

My name is Betty and I am 39 years of age. . . . I am here in prison doing 18 years and 10 months for selling crack cocaine. I have been locked up for three years already. . . . I started drinking when I was 13 years of age until I came to prison.

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<sup>1</sup> Women are no longer incarcerated in this prison. They are currently in various federal prisons around the country.

Hi I'm Joyce. I'm from Tennessee. I'm a divorced 34 year old woman with a 15 month old son. I'm here in Lex doing 8 years on a marijuana charge. My mother and little brother are doing time on the same charges. I'm blessed that mama and I are together. We have a better relationship now than ever before.

I am Bonnie. . . . I'm black age 40, mother of a 23 year old daughter, grandmother and the oldest child of eight. I'm serving 5 years on a probation violation for a DUI. After doing three years of this 5 year probation, with two years left, the judge felt that I need to start over with this five years in prison because of my addiction to 'pot.'

My name is Ruth and I'm 44 years old. I was very shocked when law enforcement officials confided in my attorney that they believed I was an abused woman. Who me abused? My husband had a short temper, some personality quirks, and yes he had dropped me on floors, knocked me out cold and pushed me down stairs, but gee I never had to go to the hospital. Little did I know that I would discover what constitutes abuse and how this affected me and my children by being in a prison.

My name is Donna. I am a 22 year old single female. This is my first time being incarcerated and I am serving a Life plus 5 year sentence for supposedly knowing that my mate was dealing in crack cocaine.

Other researchers have also begun to listen to women's voices. Galbraith (1998) interviewed formerly incarcerated women who are now living successfully in their own communities to learn about the women and their children, what hurt, what helped, and where we go from here. The following themes emerged from the women's interviews when they discussed what helped them begin to change and recover:

- Relationships with people who cared, listened, and could be trusted
- Relationships with other women who were supportive and role models
- Proper assessment/classification
- Well-trained staff—especially female staff.
- Proper medication
- Programs—not just incarceration, but job training, education, substance abuse and mental health treatment, and parenting
- Inmate-centered programs
- Efforts to reduce trauma and revictimization/alternatives to seclusion and restraint
- Financial resources
- Safe environments

### Conclusion

In our society, females' primary pathways to crime are substance abuse and attempts to survive poverty and trauma. These crimes are actually social issues. There is no dispute that female offenders have committed crimes. It is crucial, however, that the link between the crimes and each woman's drug addiction, mental illness, and/or economic distress be acknowledged. It is equally important to challenge the belief that incarceration will accomplish what is needed.

Substance-abusing females are often institutionalized, especially if they are poor, when they could be treated more effectively and economically in community-based gender-specific programs. At present, our criminal justice system reflects the invisibility of women in our society; instead, we must apply what we have learned about the lives of women and girls to those who come in contact with the criminal justice system. We must make their lives and needs visible.

Current services not only lack gender specificity; but they are often fragmented, inconsistent, and contradictory. A woman can be in a therapeutic community that regards addiction as a secondary issue, while also attending Twelve Step meetings that view addiction as a primary disease and that advocate abstinence and also participating in a cognitive-behavioral program that believes in controlled drug usage. These built-in contradictions can create confusion and lead to relapse. A female is also likely to be in one type of treatment program while incarcerated and then be treated from a different theoretical perspective when in a community continuing-care facility.

One of the most basic principles we must apply with females in the system is to "do no harm." Harm can come because of lack of safety in a facility; retraumatization; the facility's policies and procedures; or ineffective, contradictory, and non-gender-specific treatment programs. We must understand the reality of the lives of the females who come into the system in order to develop programs to serve them.

Many women and men who work in criminal justice settings struggle daily with the contradiction that a system based on power and control is antithetical to what helps women to change, grow, and heal. Creating new gender-specific programs or changing an existing program can be a partial solution. Systemic change is essential.

One of the primary goals of the criminal justice system must be to help women and girls reintegrate into society and lead productive lives. What can be done? Interventions can be made on many different levels:

- *Try to change mandatory sentencing laws.* Addicted women and girls need treatment, not prisons. Drugs are a public health problem, not a criminal justice problem. Treatment is both cheaper and more effective than prison at reducing recidivism (Finigan, 1996; Gerstein et al., 1994).

- *Choose an alternative classification principle.* Burke and Adams (1991) recommend that “habilitation” rather than “risk” assessment would be a better principle by which to classify female offenders. While security is an important consideration, equally important is the need to prepare females to function in the community. Alternative sanctions, treatment, and post-release support all contribute to habilitation. Females should be classified into the least restrictive setting consistent with safety.
- *Staff our jails, prisons, and community correctional facilities with more female wardens and correctional officers.* Female staff can serve as role models and help to reduce the risk of retraumatization by providing a sense of safety. Only those who can provide that sense of safety have the right to work with females.
- *Give supplementary training to correctional officers.* Training academies often teach information and skills that apply only to men’s facilities. Officers in women’s facilities need to understand the realities of women’s lives and the value of mutually empathic relationships, not just the rules and structure that may be effective with men, and how disconnection, addiction, and trauma affect women.
- *Teach women and girls to value life,* especially their own. It is hard for females to do so in a misogynist society where the message is that their lives are trivial.
- *Help women keep contact with their children.* Currently, women’s facilities are often set at great distances from cities where women’s children live, so that visitation is difficult. It is often their connections with their children that keep women alive and motivate them to change. It is equally essential that children’s need for connection with their mothers is supported and facilitated. Maintaining these relationships is a way to help prevent recidivism by the mothers and to help the children avoid the cycle of alcohol/drug abuse and incarceration.
- *Become aware of our own attitudes about women and girls.* We need to commit to changing our personal social systems, moving away from power and control and toward mutually empowering relationships. We need to create an environment for change and healing in our own lives.

We have the knowledge, based on sound research and experience, to design a system that frees female offenders from the cycle of substance abuse and recidivism. The rate of female incarceration need not continue to rise exponentially if we are willing to act.

The ultimate challenge as we move into the twenty-first century is to acknowledge the deep connections between the personal and the political in the lives of women and girls in the criminal justice system. If we truly want to be of service, then it is time to move beyond the culture of punishment and retribution that characterizes the system and create a culture of community and healing. It is time for transformation.

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