

PARTNERS'
INFLUENCE ON
WOMEN'S
ADDICTION AND
RECOVERY:

The Connection between Substance Abuse,
Trauma, and Intimate Relationships



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Authorship

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Overview

Substance abuse is a significant public health and child welfare problem that extends to all demographic groups. For many individuals, addiction is a chronic impairment; the recovery process may take a long time and include frequent relapses. Thus, it is important to understand the psychosocial factors that interfere with or sustain long-term recovery in addicts in order to help prevent or minimize the frequency and severity of relapse. Despite the fact that alcohol and other drug (AOD) problems affect women and men of all age groups, historically, the etiology, course, and treatment of AOD addiction have been understood from a predominantly male perspective. Research and policies that aim to understand the specific issues pertaining to female addicts, however, have been emerging for the last several decades. Some of these issues include:

- Women recover in connection, not isolation.
- Trauma is extremely prevalent among female AOD users and can be caused by sexual abuse, physical abuse, emotional abuse, domestic violence, witnessing abuse/violence, and/or stigmatization of incarcerated women, women of color, poor women, lesbians, and women with

mental illness. As a result, internalizing disorders (e.g., post-traumatic stress disorder, depression, and anxiety) and poor interpersonal skills and attributes (e.g., low self-esteem, avoidant coping skills, shame, and guilt) frequently co-occur with AOD problems in women.

- Because addiction, trauma, and psychopathology are interrelated among women, programs must be developed comprehensively to address all of these issues.
- The confluence of trauma, psychopathology, and, often resulting, poor interpersonal skills affects substance abusing women's relationships with others.
- Partners often play a large role in women's introduction to alcohol or other drugs, and in their motivation and/or ability to access treatment and remain clean and sober.
- Treatment programs need to be sensitive to the unique needs of lesbians, specifically issues related to discrimination and homophobia, sexual identity issues, isolation, and possible shame.

An ever-increasing number of programs offer “gender-specific” services to better address some of these issues unique to women’s recovery. Moreover, recognizing the large number of parenting women substance users, more and more programs are becoming “family-focused” in order to meet the needs of women and their children. Although these changes reflect tremendous progress in the substance abuse treatment field, most programs for women fail to actively engage women’s partners or provide any concrete services for them, despite general awareness of the role that they play in women’s recovery. This monograph attempts to move the field forward another step by expanding the concept of “family-focused” services to purposively include women’s partners.

Therefore, while the document will discuss interpersonal factors that may lead to or exacerbate substance abuse problems in women, it will focus primarily on how a woman’s relationship with her partner affects the etiology, course, and treatment of her AOD addiction. For instance, a partner may play a positive role by being a source of support and encouragement throughout a woman’s recovery from addiction. Conversely, a partner may have a negative influence by engaging a woman in drug and alcohol use and/or by thwarting her attempts at sobriety. Whether these negative contributions are purposeful or concomitant side effects of the partner’s own AOD use or other personal beliefs or difficulties needs to be carefully explored and understood by the woman herself and the clinicians working with her.

Defining the term “partner”

A woman interacts in significant ways with multiple people in her family and community, and each of these relationships may have a unique impact on her development and growth and in her recovery

from addiction. While the interpersonal impact of a woman’s relationship with her own parents, siblings, or friends must not be overlooked or underestimated, addressing these relationships in the treatment context is beyond the scope of this monograph. Thus, for purposes of this document, the term “partner” refers specifically to the individual(s) with whom a woman is intimately involved. This can include girlfriend/boyfriend, spouse, and/or the biological father of a woman’s child(ren). Because the majority of existing research and programmatic experience in this area addresses heterosexual relationships, that will be the primary focus of this monograph. However, many of the etiologic precursors to AOD use as well as the treatment elements discussed herein also apply to lesbians. Thus, in general, the term “partner” is used herein to refer to both lesbian and heterosexual relationships. Unique aspects of serving male partners, as well as lesbians and their partners, will be highlighted, when appropriate, throughout the text.

Monograph goals

This monograph will be useful for program administrators, clinicians, and policy makers who work with women in recovery. Its primary goals are: (1) to provide a better understanding of the role that intimate partners play in women’s recovery from substance abuse; (2) to explore strategies for helping women to assess their past and present intimate relationships in the context of their addiction; and (3) to present strategies for safely engaging partners in women’s recovery.

More specifically, this monograph delineates and describes the relational influences that are intertwined with a woman’s addiction and recovery, and discusses the positive and negative contributions and roles that partners can play in sustaining a woman’s addiction and facilitating or hampering her recovery.

It discusses the clinical issues involved in assessing the health and safety of intimate relationships; identifying and addressing the systemic and clinical factors that interfere with engaging partners in substance abuse treatment; and helping women to examine their relationships and address their interpersonal issues to develop healthier partnerships. The monograph discusses various strategies for engaging partners in women's recovery, and it addresses programmatic issues related to staffing, funding, and interagency collaboration. Finally, this monograph presents several programs that treat addicted women in the context of their relationships with intimate partners, and/or that directly incorporate partners in the treatment process.



Unique Trajectories of Addiction, Treatment, and Recovery in Women

In 1994, the director of the National Institute on Drug Abuse (NIDA) recognized that "drug abuse may present significantly different challenges to women's health, may progress differently in women than in men, and may require different treatment approaches" than those that were in place in 1994 (NIDA, 1995). Despite the surge in women focused programs and the number of women clients, many such treatment programs continue to operate according to the male model of AOD abuse instead of specifically addressing the unique needs of women who abuse AOD (Covington, 2002; Drabble, 1996; Finkelstein, 1996).

While there may be some similarities between the risk factors predisposing both men and women to addiction and abuse (e.g., family history of alcohol and drug use), certain psychosocial variables are more pronounced in female addicts than in male addicts (Marcenko, Kemp, & Larson, 2000). This section will detail some of the more compelling female specific interpersonal factors that affect women's substance use. Of particular importance to this monograph is the impact of childhood sexual abuse on women's AOD abuse, as well as the strong association between domestic violence and women's AOD abuse (Banks & Boehm, 2001; Covington, 2002; Finkelstein, Kennedy, Thomas, & Kearns, 1997;

NIDA, 1998a; U.S. Department of Health and Human Services {U.S. DHHS}, 1999). Other psychosocial issues specific to female addicts include low self-esteem, social isolation, and pressures and challenges associated with the caregiver role that is traditionally ascribed to women in American society.

Childhood trauma

Childhood sexual and physical abuse have been especially prominent in the etiology of AOD addiction among women. Studies of women enrolled in AOD treatment programs indicate that 30 to 75% have histories of child sexual abuse (Luthar & Walsh, 1995 as cited in Marcenko, Kemp, and Larson, 2000; NIDA, 2001), and these rates appear to be similar regardless of a woman's sexual preference (Hughes & Eliason, 2002). Similarly, McCauley, Kern, Kolodner, & Dill (1997) (as cited in U.S. DHHS, 1999) found a strong association between childhood histories of sexual and physical abuse and subsequent AOD addiction in adult women. In this study, the women who had traumatic childhood histories were five times more likely than those who did not to use drugs, and over twice as prone to abuse alcohol.

Many researchers suggest that use of AOD may be a distorted attempt to "escape the unresolved emotional trauma of abuse or neglect" and to undo or

mask the shame and pain associated with the trauma (Covington, 2002; Dunnegan, 1997; Najavits, Weiss, & Shaw, 1999; U.S. DHHS, 1999). In one urban study of low-income African American women, unresolved issues pertaining to maltreatment were strongly associated with severity and duration of drug usage (Simmons, 2000). This study suggests that women who have counseling/therapeutic intervention to help them cope with trauma may be less prone to abuse drugs or to relapse. Thus, failing to address women's childhood trauma histories in treatment is likely to increase the risk of relapse (Brown, Stout, & Miller, 1999; Najavits, Weiss, & Shaw, 1999; Simmons, 2000).

Female victims of childhood sexual abuse are also at risk for later sexual and/or physical revictimization (Finkelstein, Kennedy, Thomas, & Kearns, 1997). In addition, girls and women are exposed to numerous other types of sexual harassment and mistreatment in American society, all of which can make them vulnerable to AOD use. These include physical abuse, emotional abuse, domestic violence, and/or stigmatization (e.g., of incarcerated women, women of color, poor women, lesbians, and mentally ill women). As Finkelstein and colleagues (1997) suggest, "these histories and events may contribute to the worthlessness, despair, and disconnection that women substance abusers often feel" (p. 14).

Co-occurring mental health impairments

Posttraumatic stress disorder (PTSD) is "a set of emotional problems that can occur after someone has experienced a terrible, stressful life event" (Najavits, 2002a, p. 118). Given the high prevalence of childhood abuse and trauma among female drug users, it is not surprising that at least 30% to 59% of female addicts suffer from posttraumatic stress disorder (PTSD). These rates exceed those found in the

population of male addicts by two to three times and those in the general population of women, not in treatment for addiction, by three to five times (Najavits, Weiss, & Shaw, 1997; Najavits, Weiss, & Shaw, 1999). As Najavits and colleagues (1997) explain, "the syndromes of PTSD and substance abuse appear to be strongly linked. For example, the presence of either disorder alone can increase the risk of developing the other disorder" (p.3). Similar to the reliance on substances as a coping mechanism for women to contain or detach from the painful memories of early abuse, women afflicted with PTSD may also use AODs to self medicate against the distress caused by PTSD. Of particular salience to the treatment of women is that PTSD symptoms may actually worsen as women achieve abstinence (Najavits, Weiss, & Shaw, 1997), a finding that has obvious implications for women's propensity to relapse following treatment (Brown, Stout, & Mueller, 1999). For example, one study of discharged AOD addicted clients showed that relapse rates were faster for patients with PTSD than for those without PTSD (Brown, Stout, & Miller, 1999). Indeed, the comorbidity of PTSD and substance disorders indicates a much more complex and problematic treatment population who may be afflicted with numerous other high-stress life events (e.g., suicide attempts; criminal behavior; familial and relationship instability) (Najavits, Weiss, & Shaw, 1999).

Additionally, the lifetime prevalence of psychopathology among female victims of childhood maltreatment has been well documented (for a review, see Macmillan, et al., 2001). Though men with such histories also may be prone to psychopathology, the association is not as strong (Macmillan, et al., 2001). Internalizing disorders such as depression and anxiety are much more prevalent among female addicts than male addicts (NIDA, 1998a; U.S. DHHS, 1999). Recent

estimates indicate that 30-50% of female addicts experience depression or an anxiety-related disorder (U.S. DHHS, 1999). While the presence of internalizing disorders may be caused by substance use, women often use AODs to self-medicate the symptoms of anxiety and depression (Brady, 2001). Of particular relevance to treatment providers is the fact that anxiety and depression may worsen for women as they undergo withdrawal from substances (Brady, 2001). Thus, it is clear that substance abuse, mental health, and trauma are interrelated issues that require a comprehensive, coordinated, and holistic treatment approach in order to effectively intervene with women (Covington, 2002).

Low self-esteem, shame, & guilt

Frequent accompaniments to maltreatment and substance abuse in women are low self-esteem, avoidant coping skills, poor interpersonal and familial relationships and stigmatization (Camp & Finkelstein, 1997; Comfort & Kaltenbach, 2000; Nelson-Zlupko, Dore, Kauffman & Kaltenbach, 1996; Simmons, 2000). Low self-esteem is often correlated to women's substance abuse problems (Camp & Finkelstein, 1997; Finkelstein, Kennedy, Thomas, & Kearns, 1997; NIDA 2001) and is intertwined with detrimental romantic and other interpersonal relationships. For instance, it may be difficult for female addicts with low self-esteem to accurately gauge or assess the true nature of their relationships. Consequently, they may exaggerate their need for a partner who may be fueling their substance use (Amaro & Hardy-Fanta, 1995; Trepper, McCollum, Dankoski, Davis, & LaFazia, 2000). Further, having low self worth may interfere with developing healthy friendships and connections causing a woman to become increasingly isolated which, in turn, will exacerbate her low self esteem and powerlessness (Camp & Finkelstein, 1997; Finkelstein, Kennedy,

Thomas, & Kearns, 1997). Thus, many women who use alcohol or other drugs are socially isolated (Comfort & Kaltenbach, 2000; Fals-Stewart, Birchler, O'Farrell 1999; Ramler & Price, 1993) and lack social support systems to encourage their move toward healthier lifestyles.

Additionally, female addicts are more likely than male addicts to experience shame and guilt associated with their AOD use (Nelson-Zlupko, Dore, Kauffman, & Kaltenbach, 1996). Women's propensity toward feeling shame and guilt may be based on their increased likelihood of involvement with child welfare authorities and on their self-hatred for their perceived failure as caregivers (Banks & Boehm, 2001; U.S. DHHS, 1999; Finkelstein, Kennedy, Thomas, & Kearns, 1997). Their negative self image surrounding their perceptions of themselves as failing at caregiving is further aggravated by society's similar expectations of "motherhood as the ultimate, most fulfilling role of womankind" (Finkelstein, Brown, & Laham, 1981, p.46). Treatment providers, too, can compound substance abusing women's shame and guilt about their addiction, perhaps often unwittingly, by reinforcing society's expectations about the image of the ideal mother (Finkelstein, Brown, & Laham, 1981). Because women often are the primary caregivers and fear losing their children and families, they may ignore or deny their AOD difficulties; likewise, a woman's family may deny or minimize her problems due to their reliance on her as a caregiver (Weissman & O'Boyle, 2000). Taking refuge behind such a huge secret will also undoubtedly fuel her low self-esteem, isolation, shame and guilt. For lesbian or bi-sexual women, these issues often are compounded by stigma and shame associated with same-sex sexual activity, internalized and external homophobia, social oppression, and family conflict (Drabble & Underhill, 2002).



Understanding the Role of Partners in a Woman's Addiction and Recovery Process

To discuss the role that partners play in a woman's recovery process, one must first understand the importance of relationships in women's lives and in their addiction and recovery. In this light, it is critical to recognize that a partner can serve as either a great source of support for a woman or a contributor to her ongoing substance abuse.

Theoretical framework: Relational model

Finkelstein (1996; Finkelstein, Kennedy, Thomas, & Kearns, 1997) describes a framework for understanding women's AOD difficulties that emphasizes the importance of relationships in women's developmental growth. Her framework stems from work on the "relational model" developed by Miller and colleagues at the Stone Center for Developmental Studies at Wellesley College (Finkelstein, 1996). This model suggests that women have a great inherent desire to be in relationships, and their sense of self develops through their affiliation, interaction, and engagement with others (Miller, 1991). Recognizing that the self is organized and developed in the context of important relationships (Surrey, 1991), it follows that disconnections are the source of psychological problems. Disconnections can include, for example, separation from parent/family, divorce, violence, and/or sexual abuse.

Similarly, Gilligan's (1988) theoretical and empirical explorations of female identity and moral development conclude that "identity is formed through the gaining of voices or perspectives, and the self is known through the experience of engagement with different voices or points of view (p.153)." Both theoretical paradigms (Gilligan, 1988; Miller, 1984) describe the female maturation process as a distinct process from males. That is, it is the fusion of, not the exclusivity of, dependence and independence in young women's familial relationships that engender growth. Engaging and sustaining familial bonds breed self-awareness and recognition; they do not hinder it or signify stagnation in individual growth. Loyalty to and connection with peers and family members are valued attributes.

This is all in contrast to traditional theories about identity development (or more Western views), which posit that maturity is attained when one successfully individuates from the family system. Autonomy and separation are the ideal standards of growth and have often been perceived as indicators of healthy development (Erikson, 1950; Miller, 1984; Steinberg, 1990). Thus, given the cultural emphasis on independence, a woman's need for engagement with others often leads to inner conflict

when her perceptions and desires are suppressed and she is discouraged from her inherent sense of responsibility for others. As a result, women often compromise their inner sense of self (Miller, 1991); in order to be in relationships, they “learn to protect relationships at the expense of the self” (Lerner, 1988, p. 153).

Finkelstein and colleagues emphasize the importance of relationships in women’s ongoing development and the negative repercussions that certain relational impairments can have on women’s mental health. Fractured relationships and/or being isolated and disconnected are frequently associated with low self-esteem and anxiety in women (Camp & Finkelstein, 1997). Further, researchers have long noted the statistical association between relational difficulties (e.g., the loss of a loved one) and the onset of depression (Finkelstein, 1996). Similarly, problems with alcohol and other drugs may be strongly rooted in women’s past and current relationships (Finkelstein, 1996). For example, Covington (2002) suggests that some women may use drugs or alcohol to fill a void from what is missing in a relationship, and others may use to maintain a relationship (e.g., he’s using, so if I do, we’ll have something in common and be able to relate better to each other). Additionally, women are more vulnerable than men to the influence of partners on their decision to seek treatment (Riehman, Hser, & Zeller, 2000). That is, female addicts’ decision to seek, and motivation to engage in, treatment may be influenced by their partners’ AOD use, as well as other partner-related factors. Further, a recent NIDA study highlighted the male-female differences in factors related to relapse. The study noted that female cocaine addicts were prone to relapse after experiencing difficult emotional or interpersonal situations. In contrast, male addicts were prone to relapse when

they were feeling up and positive, perhaps because they were overly confident about their ability to handle a drug related binge (NIDA, 1998b).

The supportive role of partners in the recovery process

The counterpoint to the interpersonal vulnerability that may underlie women’s AOD problems is that women in recovery are especially responsive to family and community support, which can minimize their chance of relapse (Comfort & Kaltenbach, 2000; Finkelstein et al., 1997; Laudet, Magura, Furst, & Kumar, 1999; Nelson-Zlupko, Dore, Kauffman, & Kaltenbach, 1996; Riehman, Hser, & Zeller, 2000). In fact, van der Kolk, Perry and Herman (1991) suggest that “the ability to derive comfort from another human being” is a strong predictor of whether self-destructive behavior can be regulated (as cited in Johnson & Williams-Keeler, 1998). Similarly, other researchers and program administrators emphasize the inclusiveness of relationship and community partners in drug and alcohol treatment and note that these relationships are essential in sustaining healthy recovery (NIDA, 1997; NIDA, 2001).

Because social support during treatment and recovery enhances the likelihood of achieving and maintaining sobriety, partners may be an integral positive motivator in a woman’s recovery (Finkelstein, Kennedy, Thomas, & Kearns, 1997). Indeed, Riehman et al. (2000) found that drug-free male partners of female addicts are highly associated with motivating the women’s recovery efforts. Additionally, findings from studies of drug and alcohol treatment indicate that the inclusion of a partner or significant other is vital to achieving successful outcomes. For instance, utilizing couples and family therapy during and after treatment substantially improved the clients’ recovery process compared with

clients who did not have such treatment (Galanter, 1993; cited in Laudet, et al., 1999). One study of cocaine abusers showed that including significant others in the treatment was the "best predictor of cocaine abstinence" and that this was especially true for female clients (Higgins, Budney, Bickel, & Badger, 1994). Amaro and Hardy-Fanta (1995) cite research demonstrating that women in treatment have benefited from the support of a partner, and Trepper and colleagues (2000) found that couples therapy for women in AOD treatment contributed to favorable outcomes. In fact, one study found that engaging partners, regardless of their abuse problems, and focusing on relationship difficulties predicts abstinence and sustained recovery (O'Farrell, 1991; Zweben & Perlman, 1983, both cited in Trepper, et al., 2000). Similarly, family therapy was found to be a significantly effective treatment component for women addicts in an outpatient treatment program (Zlotnick, Franchino, St. Claire, Cox & St. John, 1996, as cited in Trepper, 2000).

Partner-related contributors to addiction

Whereas partners often positively influence a woman's recovery process, they also can contribute to the development or perpetuation of AOD addiction in a number of ways. First, male partners may contribute to young women's introduction to alcohol and drug use (Amaro & Hardy-Fanta, 1995; Laudet, Magura, Furst, & Kumar, 1999; U.S. DHHS, 1999). In addition, while initial experimentation with alcohol and marijuana may be normative among adolescents, a women's relationships with drug abusing men often fuel the drive toward harder drugs (Amaro & Hardy-Fanta, 1995). In fact, female addicts are more likely than male addicts to have a partner who uses illegal drugs (Lex, 1995, as cited in Weissman & O'Boyle, 2000). This foray into harder drug use, in

turn, can extend women's dependence on men. With men serving as suppliers, women often rely on them in order to maintain their addiction. It also is common for women to engage in prostitution or stealing, often under the supervision of their male partners, to support their addiction (Amaro & Hardy-Fanta, 1995; U.S. DHHS, 1999). In either case, addicts' reliance on their partners for economic support further hampers their recovery efforts and their drive toward self-sufficiency (Riehman, Hser, & Zeller, 2000).

There is far less information about the role of lesbian partners in a woman's introduction to AOD. However, bars serve as a common method for connecting with other lesbians, which puts lesbians "at risk for coupling with a partner who uses or abuses alcohol" (Hughes & Eliason, 2002, p. 286). Additionally, lesbian couples tend to spend a large amount of time together and have high levels of intimacy and shared activities (Causby, Lockhart, White & Greene, 1995 as cited in Drabble & Underhill, 2002; Hughes & Eliason, 2002). Thus, lesbian couples may begin to use AOD together, or, if one partner uses, the other may then be apt to take part as well.

Domestic violence

Violent and abusive relationships are also prevalent among female substance abusers (Kaufman Kantor & Asdigian, 1997; Weissman & O'Boyle, 2000) and are strongly associated with obstructing women's recovery efforts (U.S. DHHS, 1999). Studies have shown that 90% of female participants in treatment programs have histories of domestic violence (U.S. DHHS, 1999), and results of nationwide surveys reveal that almost three-quarters of all domestic violence incidents involve alcohol either by the victim, the partner, or both (U.S. DHHS, 1999).

Although most domestic violence research and interventions focus on male-female relationships, a growing body of literature has documented the prevalence of violence in gay and lesbian couples (Burke & Folligstad, 1999; Hughes et al., 2000 as cited in Drabble & Underhill, 2002) and the co-existing AOD use (Burke & Folligstad, 1999). In one study of 104 lesbians, 39% reported a past or present abusive relationship, and 64% of them reported that AOD use was involved (Schilit, Lie, & Montagne, 1990).

Several theoretical explanations exist for the strong link between domestic violence and AOD use. First, the prevalence of domestic violence toward women may be due, in part, to the erosion of cultural norms (i.e., appropriateness of hitting a woman)

Kantor & Asdigian, 1997). That is, abusing substances may serve as a woman's desperate coping method to minimize the trauma of the violence (U.S. DHHS, 1999). Kilpatrick and colleagues (1997) found that there is a "vicious cycle" with increased domestic violence causing increased substance abuse, and increased substance abuse fueling future domestic violent acts. In fact, there is strong evidence that "drinking by husbands increases a woman's risk for physical assault" (Kaufman Kantor & Asdigian, 1997). Whether AOD use is a reaction to the violence or a confounding factor, a woman in a violent relationship may be discouraged from seeking or continuing with treatment for fear of her own and/or her children's well being (Daley & Gorske, 2000).

Pathways to Co-Occurrence of Substance Use/Abuse and Domestic Violence

- | | | | | | |
|----------------------|---|----------------------|---|-------------------|-----------------|
| 1. Domestic violence | ↔ | self-medication | ↔ | AOD use/abuse | |
| 2. Domestic violence | ↔ | mental health | ↔ | self-medication | ↔ AOD use/abuse |
| 3. AOP use/abuse | ↔ | unsafe relationships | ↔ | domestic violence | |

(Norma Finkelstein, *A symposium on the Role of Partners in Women's Recovery*, August 2002)

and power imbalances in relationships related to employment/finances and/or family roles. Women who use AOD may be even more vulnerable to abuse due to stigmatization that partners may hold about female addicts (Kaufman Kantor & Asdigian, 1997) or by obscuring their ability to be vigilant while intoxicated (Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997).

Another theory suggests that substance abuse among female victims of domestic assaults is a *consequence* of the violence, not a precursor (Kaufman

Understanding male partner resistance

Even if a partner is not violent, he or she may convey subtle or overtly destructive messages that obstruct a woman's recovery process (Amaro & Hardy-Fanta, 1995; Comfort & Kaltenbach, 2000; Laudet, Magura, Furst, & Kumar, 1999; Riehman, Hser, & Zeller, 2000). One example of a subtle mixed-message that may be transmitted by men to their female partners was described in a study by Laudet and colleagues (1999) who conducted interviews with male partners of women addicted to

cocaine/crack. In the study, the men's derogatory perceptions and attitudes about female addicts led them to cover up and minimize the fact that their partners were in substance abuse treatment. For many of the men, having a partner who is a cocaine or crack addict was perceived as having a prostitute for a partner since the two events co-occur so frequently. Thus, to evade this stigmatic association from his friends and family, the man avoids engaging in his partner's treatment. As the authors state, "these negative attitudes may affect women and their desire to attend treatment centers" (Laudet, Magura, Furst, & Kumar, 1999).

Men's opposition to AOD treatment also may be manifested more directly toward their partners. In fact, female addicts may be physically threatened by their partners if they continue with treatment (Amaro & Hardy-Fanta, 1995; U.S. DHHS, 1999). In one study of drug abusing women, roots of the male partners' coercive actions stemmed from fear of losing their drug partner—and sometimes drug source—and fear of being abandoned by their partner (Amaro & Hardy-Fanta, 1995). Studies have shown that when both partners are AOD users, their bond to one another often develops out of their mutual addictions. The AOD use may become the focal point of these relationships (Fals-Stewart, Birchler & O'Farrell, 1999) and the glue holding the couple together, giving them a distorted sense of attachment to one another (Laudet et al., 1999). Therefore, partners' fear of abandonment is especially heightened when their partner seeks treatment before the using partner is ready. As Laudet and colleagues (1999) explain, "when a woman in recovery severs the drug bond, the attendant intimacy is also likely to be ruptured. The intimacy bond can be reestablished only if the woman resumes using drugs with her partner (p.622)."

Alterations to the family system following the recovery of an AOD addicted parent may also affect her partner. Although the prior family structure while the mother was an addict may have been unhealthy, the family members, particularly the partner, had been accustomed to certain roles and responsibilities within this system. Despite the dysfunctional aspect of these roles, family members must now adopt new patterns for relating to one another, which can be stressful for the family members. The fear of this, along with a fear of exposing family secrets, may be two other reasons that partners resist women going into treatment.



Clinical Assessment of and Intervention with Women

Given the prevalence of domestic violence and sexual abuse histories, and the related damaged self-esteem and psychological issues among female addicts, addressing the role of partners in a woman's recovery must begin with the woman. Indeed, both anecdotal and research-based evidence suggest that histories of childhood trauma and domestic violence among women not only lead to unstable relationships, but affect overall family functioning (Kappos, 2002). If these causal or related factors to the abuse of AOD are not ameliorated, recovery will be difficult (U.S. DHHS, 1999). Thus, it is critical to help women to address the underlying issues that increase their likelihood of using AOD and entering and remaining in unhealthy relationships, and to understand the role that partners play in their lives and their recovery.

Mental health, self-esteem, and violence issues

A whole body of literature exists on the assessment and treatment of co-existing mental health and substance abuse disorders, and on the assessment and treatment of female trauma survivors. An in-depth discussion of these issues, therefore, is beyond the scope of this monograph. However, at least two general points warrant repeat emphasis:

- (1) Given the prevalence of trauma and psychopathology among chemically addicted women, and its impact on the recovery process and relationships, thorough mental health assessment and appropriate treatment must be provided in any program serving this population.
- (2) Trauma-related issues, including current abusive relationships, should be assessed and addressed before, during, and after abstinence is achieved.

As previously discussed, women who have experienced trauma in their lives often turn to AOD use and may develop emotional problems as a result of the trauma and/or substance use. The sense of powerlessness that may be created by the co-existence of these conditions also makes women more vulnerable to unhealthy or abusive relationships, which exacerbate the effects of the trauma. Consequently, unless the underlying mental health and trauma issues are addressed, women are unlikely to achieve and maintain sobriety, thereby losing a primary coping mechanism, or to enter into more healthy relationships, recognizing that they deserve better. Tradewell and Williams (1994) note that, "In order to create a context for change, most women need their trauma, mental illness, abuse and/or addictions addressed simultaneously" (p. 10).

Addressing all of these complex issues is challenging, particularly given the different theoretical frameworks, staff training, and funding sources of each field. However, these challenges can be overcome by incorporating multi-disciplinary services into the treatment program, or through formal collaboration with community-based mental health and domestic violence services (see section on Administrative Issues).

Treating co-occurring mental health impairments

At least three different models exist for treating clients with co-occurring substance abuse and psychopathology (Ries, 1992). In the *serial model*, clients are treated for their addiction difficulties then transferred or referred to a separate agency for treatment of the other pathology. Given the high relapse rate for addicts with untreated mental illness, this more traditional model is often ineffective for women with major psychiatric disorders or severe substance use disorders. In the *parallel model*, clients receive concurrent but separate treatment for each illness. This model can be effective with very close collaboration, intensive case management, and ongoing cross-training, particularly for women with long-term, non-acute problems. However, it is often ineffective with acutely psychotic clients (Mason & Siris, 1992; Ries, 1992). The *integrated model* “unites and applies core concepts and methods from both typical mental health treatment and chemical dependency treatment” (Ries, 1992; p. 176). This model works best for clients with acute co-occurring disorders. Regardless of the degree of severity, good case management, a therapeutic relationship, good communication among trained staff, and gender-specific services appear to be critical to addressing psychopathology among chemically addicted women. Additionally, Harris & Falot (2001) argue that all services should be trauma-informed. That is, they should:

- take the trauma into account,
- avoid triggering trauma reactions and/or traumatizing the individual,
- adjust the behavior of staff to support the individual’s coping capacity, and
- allow survivors to manage their trauma symptoms successfully so that they are able to access, retain and benefit from the services.

Trauma-related issues also should be addressed specifically before, during and after recovery. As previously noted, PTSD symptoms may actually worsen as women achieve abstinence (Najavits, Weiss, & Shaw, 1997). Traumatic memories or related issues that may be masked or hidden during active use or early in recovery may emerge as a woman becomes sober. At the same time, many individuals experience symptoms of depression or other psychological disorders during initial abstinence or withdrawal, which often disappear within a couple weeks after initial abstinence is achieved (Sheehan, 1993; Zweben, 1992). Further, women may disclose more information as the therapeutic relationship is developed. Therefore, while initial assessment is critical to identify suicidal tendencies or conditions that require psychotropic medication or are likely to result in relapse, ongoing psychological assessment will help to detect emerging issues and distinguish between the psychological effects of substance abuse and withdrawal and pre-existing psychopathology.

In addition to assessing for trauma, substance abuse treatment programs must be prepared to address related issues in the recovery process. Group therapy focused on trauma, grief, and addiction has proven useful in certain treatment settings. Based on work by Herman (1992), Covington (2002) presents a three-pronged strategy for providing group therapy for women contending with all of these issues. She

suggests that, initially, these women need structured, supportive groups to help them deal with safety and self-care issues. These groups should be open-ended and didactic with little or no confrontation (e.g., 12-step model). As women progress and begin to recall the actual trauma, they can benefit from goal-directed, time-limited cohesive groups (e.g., tradi-

ships. This can have tremendous implications for the development of a treatment plan, and in determining if and when to involve a woman's partner in her treatment. However, in order for a woman to self-report abuse, she must feel safe physically and emotionally. Within this context, the therapist should ask targeted questions about trauma and relationships in

GRIEF WORK

Dealing with trauma is similar to grieving loss (Najavits, 2002b). Thus, treatment can include individual and group sessions to identify stages of loss and help women find resolution through grief work. In a recent study of a group therapy paradigm focused on grief issues in women (broadly defined to include historical losses related to childhood trauma and recent losses pertaining to involvement in child welfare system), participants revealed a pattern of working through traumatic loss issues, including confronting their own feelings of abandonment by their mothers' failure to protect them from trauma. Participants then could focus on their AOD difficulties and relate their grief and loss patterns to their own maternal behavior. Discussions of the women's experiences of loss in conjunction with their AOD use formed the central basis of the group's content. In addition, the therapists educated participants about the stages of grief and common beliefs of and expectations for the grieving process. Study results show that women participants in the grief group therapy program, in comparison to a non-intervention control group, remained in overall substance abuse treatment longer (McComish, et al., 1999).

tional survivor groups). After that, they are ready to begin reconnecting, looking toward the future, and addressing interpersonal relationships. At this point, they can tolerate more conflict and can benefit from unstructured, dynamic groups (e.g., interpersonal psychotherapy groups). It is important, however, that none of these groups be labeled as "trauma groups," which may scare many women away.

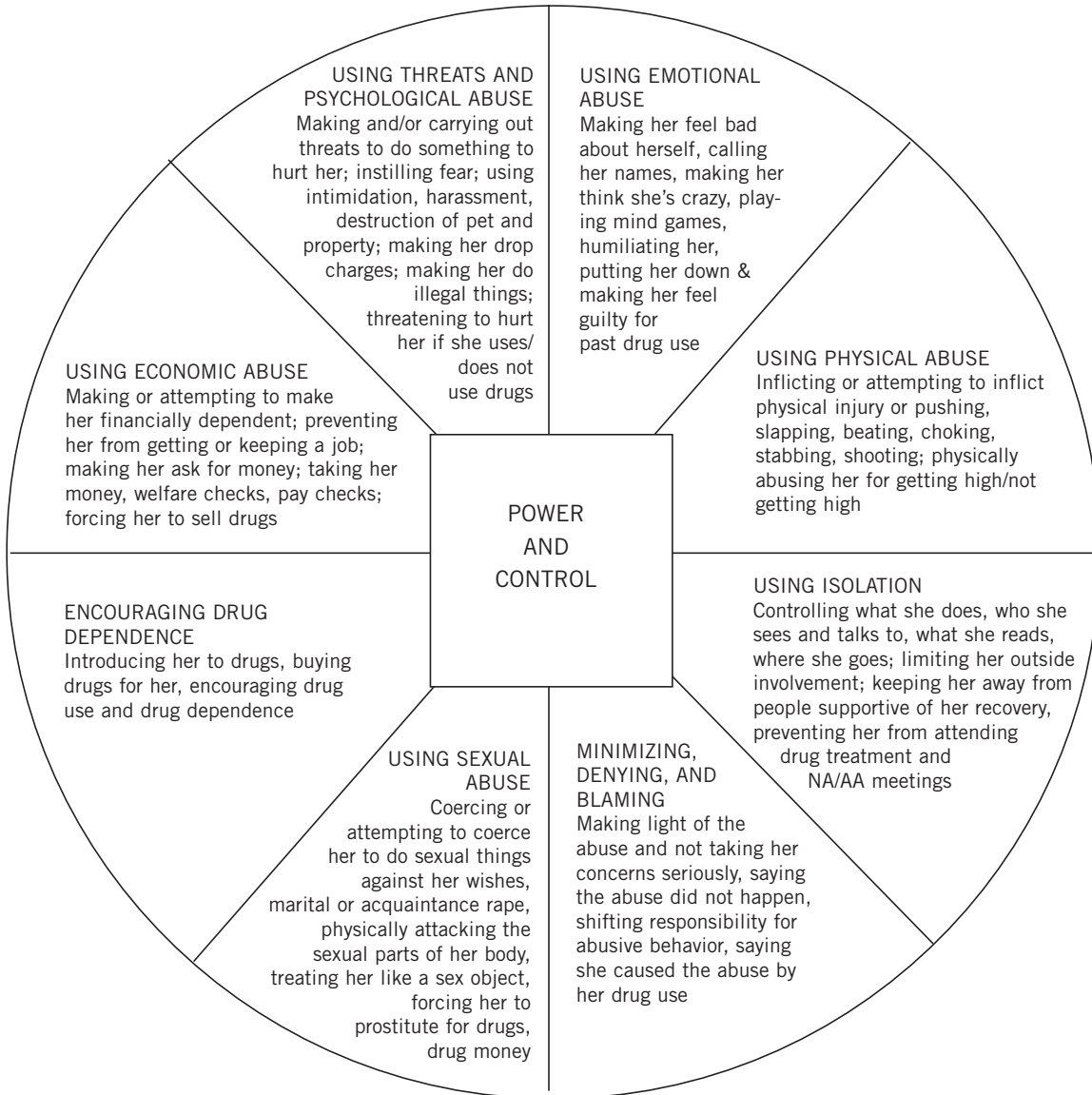
Assessing and addressing domestic violence

Given the frequent co-existence of substance abuse and violence, treatment programs must thoroughly assess for past and current abusive relation-

a culturally sensitive way as part of an initial assessment of a woman's history. In some cases, violent relationships may be the only relationship model a woman knows, and she may think of it as normal if she comes from a violent family. Therefore, as part of the assessment, it is important to explore a woman's understanding of relationships and educate her about the nature of partner abuse (e.g., what is and is not appropriate) and reasons for it (e.g., "it is not your fault"). O'Neil's (1996) *Power and Control Model for Women's Substance Abuse* can be very useful in this process (see Figure 1).

Figure 1

A Power and Control Model for Women's Substance Abuse



© 1996 Marie T. O'Neil
Adapted from: Domestic Abuse Intervention Project, Duluth, MN

Once this basis is established, it is appropriate to explore whether the woman has experienced emotional, sexual, physical, or economic abuse currently or in the past. It may be easier for women to talk about their partners than about themselves (Bland, 1997). Thus, Bland (1997) recommends starting with questions such as:

- “How does your partner show disapproval?”
- “When was the last time you felt threatened by your partner?”
- “When was the last time you felt threatened, controlled, afraid or abused by anyone in your relationships?” and
- “How often does someone hurt you?”

The Milwaukee Women’s Center (MWC) has developed a *Tool for Identifying Battered Women* (see Appendix A), which asks yes/no questions that assess: (1) whether a woman is in a physically abusive relationship or a potentially life-threatening situation; (2) subtle forms of power and control that are often foundations of economic and emotional dependence and abuse; and (3) escalation of emotional abuse that increases a woman’s danger for physical abuse. MWC also uses a 26 item *Abuse Index* (see Appendix B) to rate relationships as nonabusive, moderately abusive, seriously abusive, or dangerously abusive. These instruments are based on a woman’s response to the questions. Although this can be extremely helpful in assessing women’s situations, it is also important for staff to be aware of clinical signs that may be indicative of abuse:

- Evidence of injuries (especially to face, neck, bathing suit area, or at multiple sites or varying stages of healing) and inconsistent explanations or an unwillingness to discuss them;
- Vague somatic complaints (e.g., headache, stomachache);

- Depression;
- Fear of emotional expression;
- Depersonalization;
- Passivity
- Violence in family of origin;
- Fear of sexual intimacy;
- Hostility toward partner or other in family;
- Self-deprecation;
- Overconcern for the safety of children;
- Suicide attempts; and
- Mistrust of mental health professionals (Bland, 1997; Levy & Brekke, 1989).

While none of these signs alone necessarily implies abuse, they are red flags that suggest the need for further assessment and exploration of patterns. Additional signs also may present themselves if a woman and her partner are observed together. These include:

- A partner that refuses to leave a woman’s side, seem controlling, and/or speak for the woman (Bland, 1997);
- a hostile partner and passive woman, or a passive partner and hostile woman;
- rigid patterns of interaction;
- partner dominance of the psychological atmosphere; and/or
- extreme conflict or no conflict in the relationship (Levy & Brekke, 1989).

It is important to remember that a woman’s risk of being harmed or killed by an abusive partner increases dramatically when she starts disclosing about the abuse to professionals and/or leaves the

relationship (Najavits, 2002b; Redden, 1997). Therefore, if partner violence is suspected or confirmed, the first priority is to ensure safety for the victim and her children, and then to provide information, education, and necessary support services. Couples therapy clearly is *not* recommended in cases of active violence or where the victim feels unsafe. However, it may be helpful in certain therapeutic situations if and when both partners have received individual counseling and feel emotionally and physically safe (National Research Council, 1998). Thus, before productive dialogue between the partners can ensue, the woman must begin substantial recovery

Strategies for helping women address issues related to self and relationships

Recent treatment curricula have been developed to meet the specific needs of women substance users (Covington, 2002; Najavits, 2002a; Najavits, 2002c). Core components of these curricula focus on the client's critical examination of her sense of self and relationship patterns. Bringing attention to a woman's dysfunctional relational patterns in a therapeutic setting can help her to heal problematic connections with her children, family members, and partner(s); and it can help her to understand and conquer the causal mechanisms that may be at least

The Milwaukee Women's Center (MWC) in Wisconsin assists women in identifying and understanding how various experiences (e.g., trauma, sexism, racism) have manifested in power imbalances in their lives, and helps them to establish a sense of power and control (Tradewell & Williams, 1994). In doing this, the MWC uses a multi-disciplinary staff of clinical social workers, substance abuse counselors and a psychiatrist to simultaneously address women's trauma, psychopathology, abuse, and/or addiction issues. Key to their strategy is empowering and reinforcing a woman's ability to establish her own goals, which may or may not include sobriety, and involving her in creating solutions to identified problems. For instance, instead of requiring abstinence, a therapist helps a woman to explore the self-abusive nature of using alcohol or other drugs and how abuse or addiction maintains her oppression and powerlessness. In contrast to the traditional 12-step model of addiction, the MWC encourages women to discover and accept their personal power as a way to free themselves from dependency (Tradewell & Williams, 1994).

and feel increasingly safe and empowered, and her partner must gain self-control and learn alternative ways of dealing with emotions and resolving conflict. These issues can be addressed through domestic violence groups and services for batterers offered through community organizations or within the AOD treatment program.

partially responsible for her AOD addiction. However, identifying these relational impairments or voids must occur cautiously in a therapeutic environment that is safe and non-judgmental. Understanding the salience of interpersonal strengths and weaknesses in a woman's addiction and recovery process is underscored in the following passage by Finkelstein (1996):

“The lives of pregnant women and of women with children (who are AOD addicted) are intimately entwined with multiple individual and ‘systems’ relationships that may include social agencies, hospitals, courts, and schools, among others. Some of these relationships are healthy, but many are destructive and dysfunctional. Without recognizing the importance of these relationships in women’s lives and encompassing them within the treatment program, we are taking an extremely limited approach to helping women’s growth and development. It is essential not to blindly push “independence” or “separation” but instead to teach women how to negotiate satisfying and supportive relationships. Treatment providers should help the chemically dependent woman to examine past relationships, including issues of loss, violence, and incest; to validate and build upon her relational skills and needs; to learn how to parent successfully; and to let go of problematic, abusive relationships” (p.28).

Before attempting to assess their relationship patterns, women must first examine their self-perceptions of their own attributes, abilities, and strengths (Covington, 2002). Thus, the first of four modules in Covington’s (1999) women-specific treatment curriculum helps women enhance their self-awareness by defining “who am I” from an “internal” perspective (e.g., thoughts, beliefs, etc.) and an “external” perspective (e.g., behaviors and relationships). Techniques for doing this include writing stories and making collages about themselves. Also, as an initial exercise, they are asked to share three things about themselves that are not related to their worklife, children or relationships. The staff provide them with “quality and belief” words to give them examples, and they are eventually asked to come up with 20 words to describe themselves. They can also have other group members write down positive words describing each other, which has proven very effective at helping women to begin to change their

self-concept (Covington, 2002). Covington also stresses the importance of using these exercises to help women find congruence between their “inner” and “outer” selves.

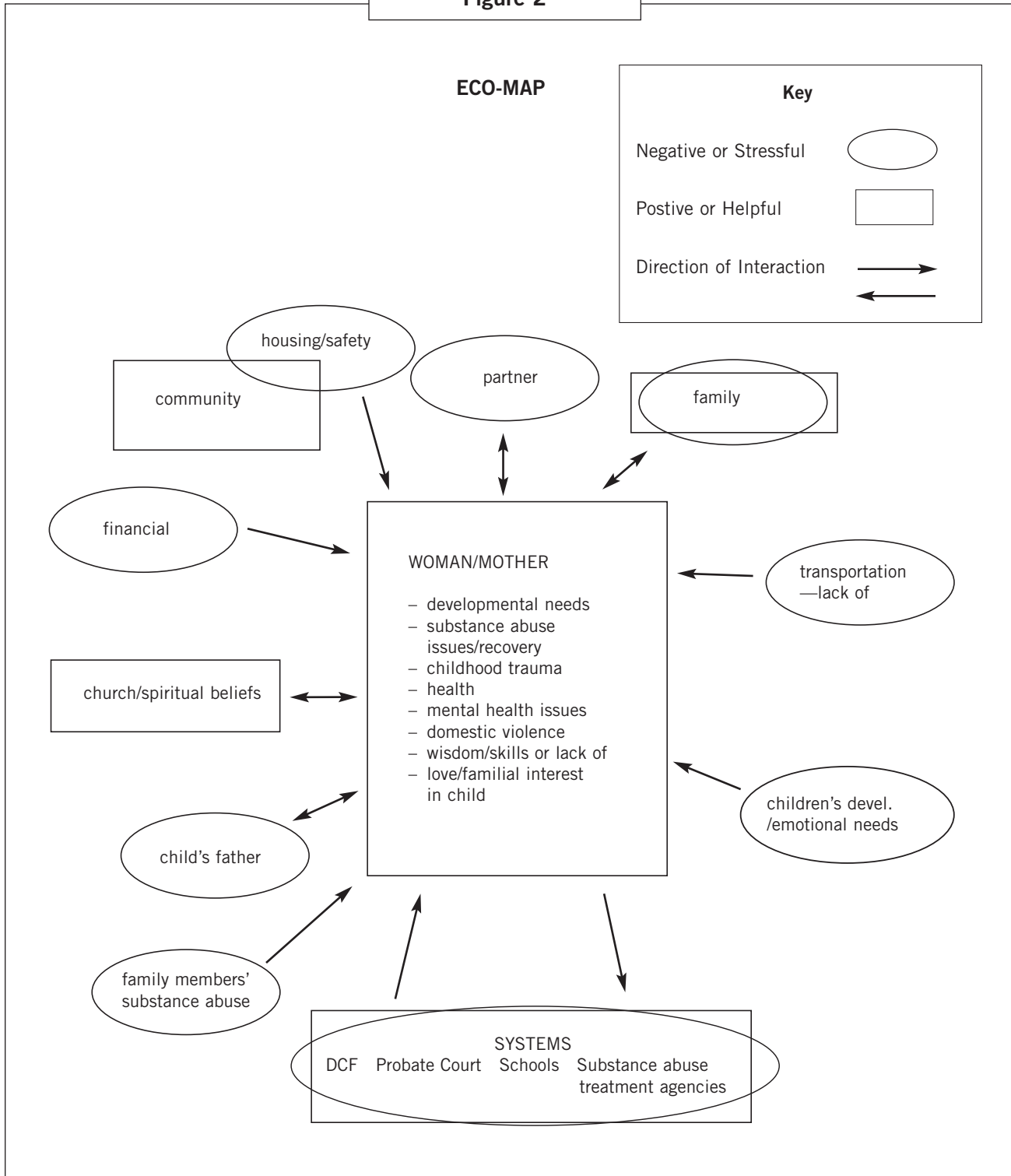
Examining relationships

As women begin to establish their “sense-of-self,” therapists can help them critically evaluate their current and former relationships and support systems. Covington (1999) covers this in her second module, which is initiated by asking each woman to reflect on her family of origin. For instance, while in group therapy, the women are asked to sketch their family and identify their role in it. Through this process, the therapist can begin to discuss issues related to abuse in families and domestic violence. This can then lead into an examination of current relationships, relationship themes/patterns, and the role of AOD in women’s relationships.

Ecomaps and the Mutual Psychological Development Questionnaire are effective tools to help women examine their past and current relationships. An *ecomap* is a map of the individual or family and the larger world in which the individual/family exists. By providing a tangible, graphic picture of an individual’s/family’s situation, its primary use is to highlight the relationships between the individual/family and other systems or individuals. Creating an ecomap involves: (1) drawing the family or individual in a circle, (2) identifying the other systems or persons that impact the individual/family, (3) determining the level of connection between the various systems, and (4) identifying resources or systems that are needed but absent, or present but unhealthy.

Ecomaps use symbols to depict the nature of each relationship and show the level of connection between an individual/family and other social systems (see Figure 2). Ideally, there will be a balance between the energy the individual/family expends

Figure 2



and the energy that flows to the individual/family. If there is a major imbalance, it may help the worker and the individual/family to target some areas for intervention. When constructing an ecomap, it is important that everyone involved in the process understands what the symbols mean. For instance, different types of lines indicate the nature of the connections between the individual/family and the different systems of their environment. A solid or thick line may represent an important or strong connection and a dotted line a tenuous connection; jagged marks across the line may represent a stressful or conflicted relationship. Or, as in Figure 2, different shaped boxes can be used to illustrate whether a relationship is helpful or harmful. In any case, it is in the process of constructing the map (not with the end product) that learning occurs. Therefore, an ecomap should be developed early in the assessment stage and changed as new information emerges or the family/individual accesses new resources or makes changes in their lives.

An ecomap can be used to help a woman identify and assess her relationships with other people in her life. This process generates important information for the therapist in terms of assessing the woman's level of connection/isolation, support network and balance of healthy and unhealthy relationships. The therapist can also use this opportunity to initiate discussions about power and control issues, as well as appropriateness, mutuality, and general health of each relationship.

The Stone Center for Developmental Services and Studies in Wellesley, MA, developed the *Mutual Psychological Development Questionnaire (MPDQ)* to measure perceived mutuality in close relationships (see Appendix D) (Genero, Miller, & Surrey, 1990). The authors of this instrument view mutuality as “encompassing diverse modes of social interaction

that facilitate participation in and growth through relationships” (Genero, Miller, Surrey, & Baldwin, 1992, p. 37). Thus the MPDQ assesses six conceptual dimensions of mutuality: empathy, engagement, authenticity, zest, diversity and empowerment. The client is asked to respond to the questionnaire from her own perspective, as well as the perceived perspective of the other person in the relationship.

Therapists can use this tool to help women assess the mutuality of their relationships and begin to address the consequences of non-mutual partnerships. For instance, in a healthy relationship, each person should have an accurate picture of her/himself and the other person in the relationship; and each should feel a sense of “zest” (vitality, energy), empowerment (i.e., the ability to act), a sense of worth, a connection to the other person, and motivation to connect with others beyond the specific relationship. Using ecomaps and/or the MPDQ or some other instrument, the therapist can help a woman explore why she is involved in certain relationships and strategies for changing unhealthy patterns.

While these tools are helpful in getting women to examine their relationships, it may be necessary to educate women about what constitutes a healthy relationship. In her *Seeking Safety* treatment manual, Najavits (2002) developed a brief checklist to help individuals identify healthy and unhealthy beliefs about adult relationships, and accompanying strategies to help explore and change unhealthy relationship beliefs (see Appendix H). Therapists should use this, and other tools, in a culturally sensitive manner (e.g., recognizing different cultural beliefs) and in the context of each woman's personal history. Other exercises that can help women explore this issue include: (1) asking women to create a vision of a healthy relationship, or (2) asking women to develop a mock personal advertisement for the perfect

partner so that they can envision positive qualities and attributes of a potential partner.

Also essential to an exploration of relationships is an understanding of healthy boundaries. Najavits (2002) defines healthy boundaries as flexible, safe, and connected; and she identifies indicators of interpersonal boundary problems associated with PTSD and AOD abuse. Often, for example, women with PTSD and/or AOD problems have boundaries that are too close or too distant. Women with boundaries that are too close may have difficulty saying no, give too much, trust too early, or get involved too quickly. Those with distant boundaries may have difficulty letting people in, be isolated, or distrust too easily. In her *Seeking Safety* treatment manual, Najavits (2002) developed an assessment tool for helping individuals identify unhealthy boundaries, and she offers role plays and examples to help women address boundary problems in relationships (see Appendices E, F, G).

One treatment program developed a group specifically to work on women's boundary issues in relationships. Each participant stated four or five boundary goals (e.g., not allowing anyone who was not supportive of her recovery to remain in her life; not subverting her needs for those of her partner, etc.) that they wished to achieve for themselves. Each week, the group participants met to discuss their respective progress in meeting these goals. The women were open and honest in discussing their progress or lack thereof, and the setting was supportive and non-confrontational. For example, if a woman failed to meet a goal that week, the other women would suggest techniques and ideas that had worked for them in similar situations. The women thrived in this healthy and supportive environment.

In an exploration of relationships, it is also important to understand the connection between intimacy and substance use/abuse. For instance, Covington (2002) points out that some women have never been in a relationship that did not involve alcohol or other drugs. She suggests having women create a timeline mapping out their first and subsequent relationships and the beginning and progression of their AOD use. This can be a useful tool in understanding patterns and the role that partners play in a woman's addiction. Other practitioners have expanded upon this concept by creating similar timelines for mental health issues (e.g., feelings of isolation) and environmental stressors (e.g., child welfare involvement, loss of job).

Finally, it is important to help women identify other harmful *and* supportive relationships in their lives. Najavits (2002) discusses several strategies for helping women to identify people who can be either a positive ("supportive or neutral") or negative ("destructive") influence on their recovery process and how to enhance or minimize these respective sources of influence. Similarly, Covington, (2002) describes an exercise in which women draw balance scales. On one side, they list all the things in their life that support their addiction, and on the other side, they list things that support their recovery. This is an excellent tool for examining unhealthy relationships and identifying and building on existing support systems. Because many women with AOD problems have more negative influences than positive, it is important to validate and build on women's strengths in relationships, and encourage and assist them to develop new, healthy social connections and community support. For instance, mentors/buddies can help women in recovery to establish healthy peer connections and reduce social isolation (Bland, 1997). Treatment programs can also create natural

support networks around common issues such as parenting, job training and housing, which also help women move toward economic independence.

The Bienvenidos program in East Los Angeles offers a peer-run alumni group for women who have completed the outpatient treatment program. While helping to maintain graduates' connection to the program, the group focuses on strengthening support, recovery maintenance, strengthening life skills, and building positive relationships. (See page 49 for program summary).

It is equally important to allow women to grieve the loss of unhealthy relationships (intimate or otherwise) from whom they are attempting to disconnect. That is, even if a relationship is unhealthy, it still represents a loss in a woman's life that may leave a void when gone. Therefore, she may need help finding resolution of these issues through supported grief work.

Addressing sexuality issues

When exploring intimate relationships, the issue of sexuality cannot be overlooked, particularly given the strong association between sex and AOD. That is, unlike men, many women's first AOD experience is connected to a sexual experience, and some women have never had sex clean and sober (Covington, 2002). As a result, some women may have fear of sex and intimacy without AOD. Additionally, some women's sexual functioning has been impacted by years of AOD use. They also may have shame or guilt about their sexual behaviors while using, and/or confusion about their sexual identity. Further, a woman's search for intimacy may lead to self-destructive and unsatisfactory sexual relationships accompanied by renewed AOD use (Finkelstein, 2002). Therefore, if the issue of

sexuality is not addressed, it can become a major relapse trigger.

To address these issues, Covington (2002) suggests beginning with a non-intrusive exercise. For instance, a therapist may ask women about if/where/when they received sex education, and about their first experience with menstruation. This can help break the ice and set the tone for moving into more difficult issues such as the relationship between sex and AOD use. To explore this, similar to the timelines described above, women might be asked to plot their sexual history and their AOD history on one graph to see the intersections. Then therapists can begin to address issues related to sexual abuse, body image and sexual identity; and they can reinforce the importance of healthy boundaries.

Clinical issues specific to lesbians

Despite the dearth of information about substance abuse treatment for lesbians, "it is incorrect and harmful to assume that all clients are heterosexual" (Drabble & Underhill, 2002, p. 409).

Therefore, all programs serving substance using women should be prepared to treat women with diverse sexual orientations. This can be done by:

- (1) linking with lesbian-specific groups in the community (which may be easier in some communities than others),
- (2) creating lesbian-specific support groups, which should be led, if possible, by an "out" lesbian clinician; and/or,
- (3) at a minimum, creating an atmosphere that feels safe to women with diverse sexual orientations. For example, use gender-neutral language (e.g., partner instead of spouse or husband) on all assessment forms and during interviews, acknowledge and affirm differences in individual and group settings, and do not tolerate anti-lesbian or discriminating comments by other clients (Drabble & Underhill, 2002).

Finally, it is important to recognize that many lesbians are parents, and some have former male spouses. Even if a biological father or ex-husband is still involved, therapists need to acknowledge and affirm the lesbian relationship, help her explore her past and present relationships, and work with whomever the woman defines as her current partner.

Engaging Partners

Although it is critical to help women address their “inner selves” and the issues underlying their substance abuse and relationship patterns, as previously noted, recovery efforts are largely unsuccessful if a woman returns to an abusive and/or substance using partner. Based on experiential wisdom from the TEG members, we know that women often risk losing their children, their sobriety, and their freedom (e.g., by violating parole conditions) in order to be with their partners. Therefore, effective treatment programs must not only help the client develop models for healthy relationships; they also must attempt to involve women’s partners in the recovery process (Finkelstein, 1994).

Most practitioners recognize the value of involving partners in a woman’s treatment process. However, this ideal involves many complex challenges including: the dual, and perhaps conflicting, therapeutic needs of both partners; safety and ethical issues; insufficient services that are available and accessible for male partners; the lack of recognition and programming designed for lesbian partners; and partners’ previous negative experience with treatment. Consequently, very few treatment programs involve partners in women’s recovery; or, if they do, it typically involves inviting the partner into the woman’s treatment (e.g., couples or family therapy)

rather than providing any direct or concrete services specifically for the partner. Following is a discussion about strategies to assess intimate partners and engage them in services.

JELANI INC., a treatment program in San Francisco, operates under the philosophy that the client’s partner is an integral aspect of a woman’s recovery. Based on their many years of experience, they have determined that it is important to involve the partner from the very first day of treatment so that the partner will feel included and engaged throughout the process. Otherwise, as they have learned, waiting to include the partner may result in the partner experiencing hostility toward and isolation from the treatment process and may thwart its progress. (See page 55 for a program summary).

Assessment

Once a woman has identified her partner(s) and granted permission to involve him/her in her treatment, a thorough assessment of that partner should be conducted with his/her consent. Ideally, someone other than the woman’s therapist/case

manager should conduct the assessment in order to gain trust and respect of the partner and maintain neutrality. This can be done through a home visiting model using a team approach (e.g., a case manager or therapist to work with the woman and a separate one to work with her partner). It also can be facilitated through collaboration with the criminal justice system, in which many partners of substance abusing women are involved.

In PROJECT NETWORK, a residential treatment program for women in Portland, OR, 95% of the women's partners had an AOD history, 83% were actively using, 79% were on community supervision, and 49% had a history of domestic violence in the current relationship (Goodman, 2002). The program partnered with the Multnomah County Department of Adult Community Justice to access this information, engage the partners in the women's treatment process, and provide services for the partner. (See page 51 for a program summary).

Regardless of who does the assessment, it is important for the professional who is assessing the partner to work closely with the woman's therapist and thoroughly discuss the assessment and plan of action (see section on Administrative Issues for a discussion about related collaboration and confidentiality issues). The assessment should consider the safety and desire of engaging a partner in a woman's treatment. Specifically, the assessment should address:

- The partner's physical whereabouts, e.g., does s/he reside in the same state, city, house as the woman/children;
- The partner's attitudes and knowledge about AOD, whether or not s/he uses, and where s/he is in the recovery process;
- The psychological functioning of the partner;

- Safety issues including a history of physical or emotional abuse, dangerous or aggressive conduct within the relationship, and the potential for violence or abuse (e.g., reports of assault, police calls to the home, drug arrests/convictions, other violent incidents);
- The status of the relationship; and
- The level of the partner's support from the perspectives of the woman and her partner, e.g., is s/he supportive of the woman's recovery; financially supportive, dependent, or abusive; involved in parenting the woman's children?

Access to the national law enforcement data system and the partner's local corrections file can be invaluable sources of information about criminal and substance abuse history, as well as mental health evaluations. Laws governing access to these records vary among states; many require a signed release of information. In other states, it may be possible and beneficial to establish a partnership with the criminal justice agency, which may provide access to useful records as well as financial and service resources for partners (see section on Administrative Issues for more information about collaboration). This information also may be accessible through the child welfare system if the family has an open case and there is an agreement between the agencies.

With or without criminal justice records, a domestic violence assessment should be administered to both partners in order to learn about the history of, and propensity for, violence. In assessing for abuse, the clinician should look for consistent patterns rather than single indicators. Some signs that a partner *may* be a spouse abuser include (Brekke 1987, as summarized in Levy and Brekke, 1989; National Research Council, 1998).

- General hostility or passivity with the clinician, family members, or others outside the family;

- High rates of psychopathology, particularly, PTSD, antisocial personality disorder, and borderline personality disorder;
- Rigid sex-role perceptions;
- Patriarchal attitudes;
- History of abuse in family of origin, either as a victim or witness;
- Feelings of being victimized by women;
- Isolation from relationships outside the family;
- Extreme jealousy;

- Inability to discriminate emotional states other than anger or frustration; and
- Extreme dependence upon the partner to satisfy emotional needs.

A thorough assessment of the partner, along with a thorough assessment of the woman, will help to determine if it is safe and desirable to involve the partner at the present time and the best way to do that. In some cases, it may be necessary to halt a partner's involvement due to issues of safety for the woman and/or the staff. In these situations, it is

The MILWAUKEE WOMEN'S CENTER developed the NEVERMORE Batterers Treatment Program in 1997. The program uses a treatment protocol that entails a psychoeducational model incorporating both therapy and education for treating physically, verbally and/or emotionally abusive behaviors in men (Higgenbottom, 1997). The program includes a one-hour individual session to determine a client's readiness for group endeavors, and to identify substance abuse or mental health issues. Although these clients have already presented as abusers by entering the program, this assessment also is useful in understanding the types, frequency and severity of abuse, as well as the perpetrator's history of abuse and "lethality potential" (e.g., how dangerous he is to himself and others (see Appendix I for the NEVERMORE assessment instrument).

Following the assessment, clients participate in 22, two-hour group sessions. The goals of the program are to help the participants end violence in their relationships, have healthier relationships, maintain their freedom, and satisfy their obligation to the criminal justice system. In working toward these goals, the program addresses legal, societal and interpersonal issues. Attempts are made to impact participants in four intrapersonal areas:

- perception of stimuli related to domestic violence;
- thinking, interpreting, and/or processing that which is perceived;
- feelings or emotions connected to the perception and thinking processes; and
- actions or behavior that stem from the above (Higgenbottom, 1997).

Some of the specific issues that are addressed in this process include decision making and problem solving skill development, and learning how to cope with and express feelings (e.g., of hurt, shame or guilt).

Additionally, the psychotherapists on staff are available for couples, marital, family, or relationship sessions following completion of the program.

crucial to assist the woman with safety planning, educate her about domestic violence emphasizing the fact that no one has the right to hurt her, and to support her efforts to sever the relationship if she chooses. Additionally, the partner should be referred to a program for batterers.

Challenges to engaging partners

In order to engage a partner in a woman's recovery, it is important to understand the realities of that individual and his/her motivation for supporting (or sabotaging) the woman's recovery and/or getting involved in her treatment. For instance, "many men are shaped by cultural influences that view men as strong, competitive, in charge, and able to go it alone" (May & Nanton, 2002, p.9). Thus, they may be reluctant to admit to a problem and resentful of any outside intervention in their lives. There also are well-established and accepted expectations that women will take care of the house and the children and be deferent to men. Often, as long as this status quo is maintained, partners will deny any problem and avoid making any changes.

In addition, based on his work with partners of women in a residential treatment program, Goodman (2002) identified the following reasons why men often are reluctant to become involved in their partners' recovery process:

- fear of humiliation and public disclosure;
- male ego (e.g., the belief that "men don't do this");
- general distrust of women's treatment programs;
- resentment of being in treatment; and
- resentment of non-biological children (i.e., partner's children from a different father).

Female partners may face a different set of challenges. For instance, they may feel uncomfortable if the program and staff are not sensitive to lesbian issues. They also may be reluctant to participate in a mostly or completely male group, particularly if there is any perceived or demonstrated homophobia.

Finally, a partner (male or female) who is abusive may minimize or excuse his/her behavior, or refuse any involvement with the woman's treatment in order to avoid taking responsibility for his/her actions. In these situations, the partner may perceive that it is in his/her best interest for the woman to continue using so that she remains "controllable" (Redden, 1997).

Strategies for engaging partners

Despite the many challenges, it is possible and beneficial to engage some partners in order to provide truly family focused treatment. To do so effectively, it is important to recognize that many partners, particularly those with substance abuse problems, have self-esteem issues or other psychosocial problems. Any insecurity they have about their relationship may become intensified when their partner enters treatment and establishes connections outside the relationship. While this emphasizes the importance of seeking, when appropriate, the partner's involvement in the woman's treatment, it also points to the need for individual services for the partner. It helps if there is something "in it" for the partner other than merely wanting to support the woman. Sometimes just inviting partners to participate and providing a role for them may be enough. However, it is imperative to address the partner's own social-emotional and concrete needs as well.

For instance, providing affordable, accessible, concrete services to meet the needs of partners is one strategy for establishing contact with them.

Helpful services might include: job training and employment, individual and group counseling, anger management, gender specific treatment, batterer intervention, counseling/assistance with child support and benefits, and legal representation. The TEG members documented that services often are not available to men, or they have to pay a fee for services that may be available free-of-charge to women by virtue of their involvement with the welfare or child welfare system. Therefore, providing accessible, subsidized treatment services for partners of women in a program may be an excellent strategy to get them in the door. These services may be provided through the same agency that is serving the women or through established linkages with other agencies in the community. In either case, safety issues are

paramount. For instance, women in abusive relationships may not feel safe knowing that their partners are on-site. At the same time, men and other partners need to have a safe environment in which to divulge personal information, and they may not feel comfortable going into a “women’s program.”

Regardless of where the services are located, experience suggests that if you tell women about the services available to their partners, they will bring them in. At the same time, some women may not have success at engaging their partners if the partners themselves are not motivated, particularly if they are actively using, or if there are domestic violence issues. Some providers suggest that children can be a motivating factor for parents; however, drugs may take precedence for active users.

Initially *BIENVENIDOS FAMILY SERVICES* in East Los Angeles, CA, was designed for women and children. Recognizing that women in the program were going home to their partners, *Bienvenidos* began to develop services for the partners. Currently, male partners of women in treatment can receive free services through *Bienvenidos’ Latino Fatherhood Program*, which is designed to reinforce fathers’ positive involvement in the lives of their families and community. Classes offered include anger management, male involvement groups, fatherhood class, and a *Compadres Network*. Partners also can receive outpatient health and mental health services through *Bienvenidos’ Outpatient Mental Health program* and *Men’s Health Center*, all located in the same neighborhood.

Similarly, *MILWAUKEE WOMEN’S CENTER*, in Milwaukee, WI, which began as a domestic violence shelter for women and children, currently provides a host of services for women’s partners. This includes *MWC’s NEVER-MORE* group treatment program for men who are abusive to their partners, and the *Fatherhood Program*, which provides group and case management services to men. Partners also can receive individual, couples and family counseling through *MWC’s Behavioral Health Clinic*. All of these services are located on various floors of the same large building (e.g., programs for men or batterers are located on one floor, and services for women are located on other floors), and care is taken to assure that batterers’ treatment groups are not held in the same area as the women’s groups.

Another possibility is to mandate fathers' participation through the child welfare and/or criminal justice system. Inequities in the current child welfare system often mandate treatment for the mother while simply encouraging it for the father. This undoubtedly reflects the reality that mothers are more commonly the primary caregivers. Similarly, American society has historically focused more on the criminalization than treatment of male addicts (Goodman, 2001). As a result, many of the issues underlying a man's addiction or predisposing him to addiction go undetected and unaddressed. More equitable treatment of both parents by the child welfare and criminal justice systems might go a long way toward engaging fathers in their own recovery and the recovery of their partners.

JELANI INC., in San Francisco, CA, provides residential treatment to entire families referred by the child welfare system. Both concrete and therapeutic services are provided to each individual family member (including the father or woman's partner), to the couple, and to the family. Different individual counselors work with the women, the partners, and the couple to meet the specific needs of each. Jelani also operates separate gender-specific residential facilities for men and women when space is not available in the family program, or when it is not appropriate to place the couple together (e.g., when there is a history of violence). (See page 55 for a program summary).

The Village's FAMILIES IN TRANSITION Program in Miami, FL, also permits couples and entire family units to reside in treatment together. They, too, provide services for all family members and operate separate gender-specific residential programs. (See page 50 for a program summary).

Engaging partners through peer groups, home visiting and child focused services

Assuming that services are available for partners, the challenge then becomes how to actively engage them in supporting the women and addressing relationship issues. The first step is to establish a trusting, therapeutic relationship with the partner independent of the woman. A number of TEG members have found that men need to feel comfortable sharing their feelings before they will talk to a therapist. In most cultures, this is not something that is natural or comfortable for men. Peer groups can be helpful by normalizing the process of sharing feelings. However, because men often have an avoidance of groups and public exposure, the group facilitator is critical. It may work best if it is a peer or someone from the community in order to gain respect from the group members. A partner's case manager, parole officer (if there is not a contentious relationship), or someone else with whom the partner has already established an individual relationship, also may be effective as a group facilitator.

Similarly, when working with female partners, programs should conduct or link with lesbian-specific recovery groups in the community. Drabble & Underhill (2002) note that it is helpful to have an "out" lesbian clinician facilitate or co-facilitate these groups. They also suggest that if it is not possible for a group to be lesbian-specific, its composition should at least include other lesbians in order to engage them in the process. At the same time, however, Goodman (2002) reports that lesbian partners who attended a male-facilitated partners' support group actively participated, shared many of the same issues and concerns as the men involved, and were actually instrumental in helping men to open up and engage in productive dialogue.

The LA BODEGA DE LA FAMILIA program in New York City strongly believes in reaching out to multiple family members and other community supports in addressing participants' AOD difficulties. Because La Bodega operates in the same community where families live, it has found that participants are more receptive to allowing La Bodega into their lives. Although the program encounters initial resistance on the part of some of the clients' family members (e.g., "it's his problem, why do I have to get involved in treatment?"), staff find that this attitude dissipates over time. In fact, because family members and partners frequently are overlooked by the system, they often come to appreciate that someone is concerned about their struggles and their well-being. This is their opportunity to feel listened to and validated. As one La Bodega participant commented, "our first meeting was the first time that anyone asked me why I hurt and what I might need." La Bodega also notes that a critical factor in its success is utilizing bilingual staff who can relate to the largely Latino population that pass through the always-open door of La Bodega de la Familia. (See page 56 for a program summary).

Other strategies for establishing relationships with partners/families, or engaging them in discussions include: organizing functions or social outings for partners; contacting them by phone or at home; or taking them for a drive or out for coffee to provide a more neutral, less threatening place to talk. Home visiting strategies that include the whole family also may work. Typically, the dominant focus of home visits is on mothers and children (Chalmers, 1992). Often this is because the partner is resistant or not there, the woman's "gatekeeping" actions prevent contact with the partner, or the home visitor has

not received sufficient training or is fearful or uncomfortable approaching the partner. Therefore, a team approach (e.g., a male and female) or a male peer who is sufficiently trained can be more effective at engaging the partner. Scheduling the visits at a time when the partner is likely to be home also might provide a better chance of actually meeting with him/her.

BIENVENIDOS FAMILIES SERVICES in East Los Angeles, CA, provides home- and center-based family support and case management services. To engage partners, teams of male and female counselors, or male workers alone, go to the homes in the evenings when men are more likely to be home. They honor the families' homes and culture; recognize the shame and guilt of the partner; and offer them concrete services such as housing assistance and health care.

Similarly, child-focused services may be less threatening and more helpful in engaging both partners, particularly during pregnancy or right after the birth of a child. This time is often seen as a window of opportunity to intervene in the life of a substance using woman, but this thinking is rarely expanded to include the father or lesbian partner. Men who have had inadequate or abusive parenting or parental absence may have little motivation to assume the role of father due to limited ideas about how it can enhance a sense of self and manhood, contribute to a family's cohesion and sense of well being, and strengthen a couple's relationship. Therefore, addressing these issues in the context of parenting can help to get the partner more involved in his/her family and open doors to begin discussing relationship and substance abuse issues.

Relationship counseling

Individual and group couples counseling can be a helpful strategy to engage partners in addressing relationship issues. In one study, for instance, couples therapy was offered for women in a residential treatment program and their partners (Trepper, McCollum, Dankoski, Davis, & LaFazia, 2000). The therapy focused on defining and understanding current dysfunctional patterns of couple interaction, with a particular focus on drug use, and the roots of these patterns from both partners' families of origin. By exploring multi-generational patterns, the therapists helped couples to see their problems as reflections of what they learned in their families of origin rather than as personal failures. As couples began to identify dysfunctional patterns in their own relationships, the therapist helped them make plans for each partner to change their part in the pattern, to put those changes into practice, and to evaluate and refine the plans, which could include choosing not to stay in a relationship.

Because women in this study were in residential treatment, their limited contact with partners outside of therapy made it difficult to work on their relationships. Thus, whereas this therapy model may be more practical in an outpatient model, the residential program revised their goals as follows: to "(a) develop some awareness on the part of both the woman and her partner that the partner needs to be involved in the process of recovery by helping to change couple patterns; (b) develop some awareness of what the couple patterns are that need to change...and why those patterns are there...; (c) develop a vision of what change in those patterns might look like; (d) prepare to make changes in couple patterns when the woman is discharged; and (e) develop an awareness of relational danger signs that might indicate impending relapse, as well as plan

how to deal with such problems if they arise" (McCollum & Trepper, 1995, p. 2, as quoted in Trepper et al., 2000, p. 205-206).

Using these goals, the program offered three types of relationship-focused therapy: (1) Systemic Couple Therapy for both partners together was offered for women who had partners willing and able to participate; (2) Systemic Individual Therapy for the woman alone was offered for those whose partner was unable or unwilling to participate; and (3) women who did not have partners at the time were offered a modified version of the therapy that focused on past relationships and patterns. Some of the women started in couples therapy and changed to individual therapy as their partners dropped out. However, those in individual therapy also appeared to benefit from the opportunity to discuss their past and present relationships (Trepper et al., 2000). This finding is consistent with a more recent study by Winters and colleagues (2002), that found that behavioral couples therapy with female AOD users is no more effective than individual-based treatment. Thus, although some partners refuse or are unable to participate in a woman's treatment, it is still important for women to address relationship issues in a therapeutic setting.

In fact, therapy with individual partners can effectively help to make changes in relationships (Ziegler & Hiller, 2001). Although the "other partner's behavior is outside a client's control, the interactions that support positive change are not—one partner can trip a positive change cycle by shifts in his or her perceptions and behavior" (Ziegler & Hiller, 2001, p. 181). Therefore, the emphasis should be on helping the client to identify changes that she would like the partner to make, and then focusing on changes that she can make to generate the possibility that her partner will change. In relationship therapy

with a partner who is reluctant to come in, it is important to acknowledge and honor his/her belief that there is no good reason to be in therapy (Ziegler & Hiller, 2001). However, the therapist might ask questions such as, "What do you think we could do together that might make some positive change in your life?" (Ziegler & Hiller, 2001). This process might also be applied to a partner who is reluctant to acknowledge a problem or entertain the idea of relationships counseling, but may be mandated by the criminal justice system to attend therapy. The therapist might ask, for instance, "Are you interested in getting your partner/the system off your back so you don't have to come anymore?" By validating the client's feelings, there is a better chance of engaging him/her in therapy, which is a critical first step in addressing more difficult issues (Ziegler & Hiller, 2001).

These studies suggest that relationship enhancement therapy can be beneficial to women and their partners individually or together. However, unless both partners in a couple have begun to address their own issues individually, couples counseling with both partners together, particularly in a group setting, is likely to be ineffective (Goodman, 2001). For instance, in Trepper et al's (2000) study, women in their first four weeks of treatment did not do well in couples therapy because they were still dealing with detoxification, the early effects of abstinence, and crisis management around child welfare, courts and public assistance, and they were not ready to deal with relationship issues. Recognizing this, many treatment programs for women have a period of at least 30 days for stabilization, assessment, and early recovery support before partners or other family members are invited into the process. However, because partners typically are not provided this opportunity, they are not prepared to address rela-

tionship issues that the women have been working through in their own therapy (Goodman, 2001). As a result, they may refuse to engage in the process or become confrontational and aggressive during couples sessions. Thus, couples therapy with this population is likely to be more effective if both partners receive individual services preparing them for the process.

Project Network, an Oregon residential treatment program for women, collaborated with the Department of Adult Community Justice to develop a couples group. The group, which is co-facilitated by a female therapist and male parole officer, meets for 14 weekly, three-hour sessions, during which time child care and food are provided. Prior to joining the couples group, all the women begin to work through their own various psychosocial and relationship issues during a 30 day blackout period. Similarly, the partners receive case management services by a male parole officer, and they attend a partners' group designed to prepare them for addressing relationship issues in the couples group. Specifically, they address issues related to ego and societal role expectations, love and intimacy, sex and control issues, and anger and guilt about what they have done to their partners and children. Goodman (2001) notes that the men have spent over 20 hours discussing the issue of sex in the men's group before they were ready to address the issue in couples group.

It is equally important to provide parallel, gender-specific support groups to help women and their partners separately process issues that arise in the couples group. Individual couple therapy also should be available to help address specific concerns as they arise. For instance, as women begin to address their

own personal issues and gain self-esteem, they may no longer accept the way that they have been treated, and may expect more out of their relationship. This type of issue can be addressed through couples counseling, and through individual counseling where a therapist might help a woman explore her options. With couples that have a history of violence, therapists and programs must be particularly vigilant to ensure the safety of the woman when things discussed in group or therapy are revisited at home. For instance, therapists should maintain close contact with a partner's parole officer if he is under supervision. Maintaining contact with the client through in-home visits and/or regular phone calls also may help to ensure the woman's safety.

Administrative Issues

Because the treatment of substance abusing women, and the involvement of partners in this process is so complex, interdisciplinary and interagency collaboration is necessary. Simple referrals to other programs are not sufficient with this population. Thus, services must be coordinated through a single agency or through close coordination and case conferencing among several agencies.

Covington (2002) stresses the importance of developing programs around a solid, theoretical framework that provides continuity and congruency for the staff and the clients. She notes that, in order to help clients find congruence in themselves and begin the healing process, programs must have integrity, congruence and clarity. This requires theoretical integration of different models of addiction such as the 12-Step/disease model and social learning theory, as well as theories of psychological development (e.g., relational model) and trauma (Covington, 2002). When applied to practice, staff of congruent programs all convey the same message to clients and base their treatment on shared philosophical beliefs and values about the treatment of women.

Similarly, interdisciplinary work suggests that “entities, agencies, and departments are working

together, cooperating, and engaging in shared decision making” (Bouchard, 2001, p. 16). This requires regular formal and informal communication among staff members. For instance, a woman might have a substance abuse counselor, psychologist, and case manager, among others, working with her at any given time. It is critical, with the client’s consent, for the various staff to work closely together in order to most effectively assist the client. Team meetings often are used to discuss each client and develop a single service plan based on the goals developed by each discipline. Additionally, the woman’s case manager/therapist should work closely with her partner’s case manager/parole officer/therapist in order to accurately assess the safety of the situation and better understand the best way to work with each partner individually and as a couple. In order to do this, it is critical to understand the legal and procedural issues related to involving and identifying partners of women in treatment.

Whereas some agencies are able to hire multidisciplinary staff to address the varied and complex needs of their clients, most require some form of interagency collaboration either because of functional or resource limitations and/or because it makes sense. Key agencies/programs to involve in the

comprehensive treatment of substance abusing women and their partners include:

- AOD treatment (residential or outpatient);
- Mental health;
- Domestic violence for victims and batterers;
- Criminal justice; and
- Child welfare.

Other collaborative partners may include agencies/individuals in the following areas: welfare-to-work programs; housing; education; health care (e.g., a nurse practitioner to dispense psychotropic medication); fatherhood programs; community-and faith-based organizations; cultural organizations; lesbian organizations; and the media.

Relationships among these agencies must be well-established and based on shared problems, values and vision in order to provide congruency and a fluid system of care for women and their families. This can be extremely difficult given the different philosophies and values, turf issues, and confidentiality issues. Therefore, all collaboratives should focus on relationship building and value clarification up front. The first step is to identify potential partners and establish dialogue with them to develop trust, interdisciplinary understanding, and working relationships. Sharing assessment tools, strategies and protocols can be helpful in this process. Initial meetings also should focus on the mission and roles of each team member, and the rules governing confidentiality (Monk, 2001).

Additionally, formal agreements such as Memorandums of Understanding or Memorandums of Agreement should be developed to address issues such as sharing of information, cross-referrals, access to services, treatment planning, specific roles and

responsibilities, and cross-training; and joint policies and procedures should be developed whenever possible. Some agencies may even dedicate staff on a contractual basis to work on-site as part of the treatment team.

JELANI INC., which provides outpatient and residential treatment for women, men and families in San Francisco, CA, has an on-site therapist that is out-stationed and funded by a community mental health organization. Although the therapist is not employed by Jelani, she is an integral member of the treatment team, and provides invaluable services to women, men, children, couples and families served by Jelani's various programs.

In addition to collaboration at the direct service level, it also may be helpful to develop inter-agency councils that involve multiple systems pertaining to the various needs of women with substance problems and their partners (e.g., substance abuse, criminal justice, child welfare, housing). These councils can help to plan, create and coordinate services, and address larger policy issues (Foster-Fishman, Salem, Allen, & Fahrbach, 2001).

The following principles can provide guidance in any collaborative effort among various agencies (Stark, 1999):

- Build and maintain trust;
- Agree on core values;
- Focus on common goals;
- Develop a common language;
- Respect the knowledge and experience each person brings;
- Assume best intentions of all partners;

- Recognize strength, limitations and needs, and identify ways to maximize participation of each partner;
- Honor all voices; and
- Share decision making, risk taking and accountability.

Additionally, the following elements are considered key to effective collaboration: strong relationships and mutual trust, cultural competence, meaningful involvement of families and other caregivers, a common vision, a focused work plan with measurable goals, commitment of all, clear decision making processes and open communication, and an understanding of the political environment (Stark, 1999).

Staff training

All staff working with substance abusing women and/or their partners must receive comprehensive, multidisciplinary, and on-going training. For instance, Covington (2002) notes that it is not enough just to have specific staff available to address trauma-related issues. In order to provide a consistent message for clients and address safety issues, it is

important for all staff involved with substance abusing women to be “trauma informed,” i.e., knowledgeable about violence against women and the impact of trauma (Harris & Fallot, 2001). They also must receive training on assessing for histories of trauma and current abusive relationships.

Additionally, all staff should have a clear and consistent understanding of, and attitude about, the role of partners in women’s recovery. For instance, staff must realize that their goal is not necessarily to get a woman to leave an unhealthy relationship, but rather to assist her with safety planning, provide information, support her decision-making and, when appropriate, the leaving process, and convey the message that “no one ever has the right to hurt her to get their way” (Bland, 1997). Further, all staff working with women should be sensitive to lesbian issues and should carefully examine their own assumptions and biases about same-sex relationships as well as other issues such as men, abusive partners, and cultural differences.

Covington (2002) suggests several innovative strategies for engaging and training staff. First, to help staff to connect on a different level, she recommends sharing exercises such as passing a

GUIDING PRINCIPLES FOR CLINICIANS WORKING WITH LESBIANS IN ADDICTION TREATMENT

- 1. Obtain consultation for countertransference issues.**
- 2. Examine one’s practice for more subtle forms of bias and ignorance.**
- 3. Actively seek research data and other sources of information to continuously learn about issues related to the treatment of lesbian clients.**
- 4. Develop knowledge about lesbian community resources and lesbian-friendly services for client support and aftercare services.**

(Drabble & Underhill, 2002)

cookie(s) around the table, and as each staff person takes a bite, s/he shares a favorite childhood treat. Covington also recommends holding a staff support group once a week so that staff can go through a similar process before doing it with the female clients. This can help sensitize staff to the issues and process.

Additionally, programs that provide couples therapy should give careful consideration to who should provide it. In the interest of neutrality and trust, for example, it is not ideal to have the woman's therapist conduct couples therapy. Trepper et al. (2000) suggest that, although a trained marriage and family therapist is the most appropriate clinician, AOD counselors can provide relationship enhancement counseling with appropriate training and supervision. They suggest that the minimum requirements a counselor should meet to offer this type of therapy for substance abusers is: a chemical dependency certificate with at least one year of experience, a clinical, counseling, or related degree (masters preferred), and some experience working with couples, families, and/or groups (Trepper et al., 2000). In addition, their training should include a review of relationship enhancement within a substance abuse treatment milieu, practice through clinical simulation, and gender and cultural issues.

Cultural issues

"Culture influences what we identify as a problem, beliefs about the origin of a problem, how to resolve it, and which types of helpers we believe are appropriate to assist in problem resolution" (Weaver & Wodarski, 1995, p. 215). Additionally, ethnic groups and, indeed, families differ with regard to relationships, rules of relationships, strategies for resolving conflict, norms about self-disclosure, and values around independence. Therefore, it is critical

for staff working with women and their partners to take the time to understand each client's views and perceptions in these areas.

The first step in this process is to recognize one's own world view, biases, pre-conceived judgments about female addicts and their partners, and the effects these have on the therapeutic relationship. It is also important to understand the influence of institutional biases, as well as the "norms, cultural characteristics, and history of the client's cultural group" (Weaver & Wodarski, 1995). However, it is equally important to recognize the large variation within cultural groups, and not to make assumptions about a client based on her or his ethnicity, culture, or skin color. Thus, staff need to be trained in how to ask questions in a way that is culturally sensitive, non-offensive or judgmental, but that elicits useful information. Further, in the early part of engaging a client, there should be an opportunity to listen to the client describe her experiences, background and beliefs. For immigrants, it is also important to learn about their immigration history, status, and level of assimilation. Additionally, an acculturation scale can be helpful in assessing an individual or family, particularly immigrants, with regards to sex roles, power sharing, and other critical issues related to relationships (see Appendix J for the *Short Acculturation Scale*). All this information can be helpful in understanding how each individual's experiences, values, and meaning of family, children/parenting, relationships, and substance abuse affect her own recovery process and involvement with her partner. The same practices also should be applied to a woman's partner, whose values and beliefs may differ from the woman's. Thus, it is critical for programs to be grounded in theory but flexible enough to accommodate clients with different backgrounds, values, and beliefs.

Evaluation

A thorough evaluation of any program is critical to its development and sustainability. Information gathered through a carefully designed evaluation can facilitate program improvements and justify ongoing, new or increased funding. Thus, an evaluation should entail both a *formative* component to measure the program's implementation of service delivery, and a *summative* component to measure the impact of a program on client outcomes. Measuring the former will help programs identify strengths and weaknesses of their treatment models, staffing procedures, outreach to target populations, and other critical service components. Evaluating the summative impact of the program on clients may help programs understand the ongoing needs of their client base and the extent to which the program addresses these needs.

The gold standard for a rigorous program evaluation is random assignment of clients to different service packages—or the inclusion of a non-treatment control group—so that the differential impact of the respective interventions can be measured. This is the most effective way to assess what works for what kind of client. For instance, it would be ideal to compare a randomly assigned group of women whose partners are involved with their treatment to a group whose partners are not involved. However, because logistical or ethical reasons may preclude such an approach, quasi-evaluations that do not utilize an experimental design are also an effective source of information. Although this format does not result in the broad comparison to other clients and populations, it may track participants' progress relative to their pre-program status (pre-post method). For example, are women, whose partners received services and supported them in treatment, better off after treatment than before?

Additionally, program evaluations are critical for moving the substance abuse field forward because they can more definitively answer such questions as: Who seeks substance abuse treatment? Who benefits? Who fails to make any progress? What factors contribute to “success” or “failure?” Which service models are effective for which kind of client? How can programs improve their operations to successfully reach a population? What is the optimal duration of service delivery? What are the costs associated with starting up and implementing a program? In order to expand the availability of services and funding for partners of women in treatment, it is critical to document the successes and challenges of those programs that already are providing these services. Specific assessment indicators for programs serving substance using women and their partners may include the following.

Program Information:

- Logic model or overall mission of program and the extent to which the program adheres to this model;
- Types of services and interventions offered;
- Staff qualifications and training;
- Duration and cost of services; and
- Partnerships with other local treatment providers.

Descriptive Information on Clients and their Partners:

- Demographic data such as age, ethnicity, gender; employment; family size; income; education;
- Substance abuse history, e.g., type, how it began, duration;
- Criminal involvement and background, including child welfare and domestic violence involvement;
- Past and current relationship functioning and difficulties;

- Family and community support;
- History of childhood and/or current victimization;
- Mental health history and current status; and
- Parenting and life skills assessment;

Outcome Information:

- Length of stay in program;
- Post-treatment alcohol or other drug use;
- Reunification efforts;
- Psychological functioning;
- Status of relationship with partner and/or others;
- Incidence of domestic violence;
- Change in partner's role, level of support, and knowledge about/use of alcohol or other drugs; and
- Change in child's placement and emotional well-being.

These indicators can be measured through qualitative and quantitative information collected through a variety of mechanisms, e.g., client questionnaires, provider reports, standardized instruments, medical and case records, observational data, and community surveys.

The La Bodega de la Familia program in Manhattan's Lower East Side is committed to data collection and analysis to ensure that its programs are accomplishing their program objectives. While the evaluative component of La Bodega is ongoing, one recent piece of research shows promising results. A year-long evaluation of La Bodega by the Vera Institute of Justice indicates that those participating in La Bodega's program had

reduced drug use in all categories; few rearrests; improved treatment outcomes; and enhanced well-being of family members.

It is important, however, to collect only information that is critical to the evaluation and improvement of the program. Superfluous data collection is cumbersome for the staff and clients and unnecessarily invasive. Standardized instruments can be helpful in measuring certain specific outcomes, and they save time involved in creating new assessment tools. Be aware, however, that these instruments do not always come free, and they may require trained interviewers/testers and significant time. Also, one must choose among the plethora of instruments available to find ones that fit a particular program's structure, clientele, objectives, and resources. Finally, remember that before any data are collected, the client must agree in writing to participate in the evaluation and grant permission for specific agencies to share information about them. Along with informed consent, Universities and other research organizations have strict Human Subjects criteria that must be met before any research or evaluation project can begin. This means that all data collection procedures are strictly scrutinized by an impartial panel (typically called an Institutional Review Board or IRB) composed of University faculty and staff. These IRBs have strict standards for protecting the health, safety, and confidentiality of the research participants. All evaluators must factor this IRB review process into their research plans.

While this process can seem daunting and overwhelming to service professionals, it can be developed through collaboration with a University or research organization. Although the service providers will need to be involved in the development of the

evaluation plan and ongoing data collection efforts, the third-party evaluator can guide and support the process, and assume responsibility for the technical management and analysis of the data. The following section identifies some potential funding sources for evaluation efforts.

Funding

Addressing the complex needs of substance using women and their partners requires multi-disciplinary approaches, interagency collaboration, and funding streams that make this possible. Unfortunately, traditional funding streams have been rigid and focused on a single service component. Federal policy is beginning to reflect the co-occurrence of domestic violence, substance abuse, and child welfare, and increasingly supports the concept of “family-focused” services. However, that concept continues to imply mother and children, and generally ignores the presence of the mother’s partner and/or the children’s father. Although there is a growing national movement of fatherhood initiatives, programs are still forced to piece together various funding streams in order to truly provide family-focused services. This is possible using a combination of federal, state, and local public funds and private funding through foundations, corporations, individuals and local organizations.

As illustrated below, a large percentage of federal funds are passed through various state and local public agencies. Additionally, states generally have supplemental programs in most of these areas, e.g., child welfare, substance abuse, and mental health. Further, private contributions and foundation/corporation grants often provide more flexible funding to fill in service gaps or initiate innovative services. Many foundations also value funding program evaluation.

Although federal policy and funding initiatives change from year to year, the following federal programs or agencies are potential sources of funding for different aspects of programs that serve families affected by substance abuse.

Department of Health and Human Services

The U.S. Department of Health and Human Services (U.S. DHHS) is the key federal agency with programs that directly support demonstration, research, training, and service delivery activities that address the problems of child abuse and neglect, family welfare, and behavioral health issues. Within U.S. DHHS, at least three agencies administer programs that fund services for families affected by substance abuse: Administration for Children and Families (ACF), Substance Abuse & Mental Health Services Administration (SAMHSA), and National Institutes of Health (NIH).

1. Administration for Children and Families

*Mary E. Switzer Building
330 C Street SW
Washington, DC 20201
Website: www.acf.dhhs.gov*

Through various bureaus and offices, ACF administers numerous grants to state and local public and private agencies to provide services to children and families. Within ACF, the **Children’s Bureau** is responsible for assisting states and communities in the delivery of child welfare services designed to protect children and strengthen families. The Children’s Bureau administers six discretionary grant programs including the *Abandoned Infants Assistance* program and *Child Abuse Prevention and Treatment Act (CAPTA) Research and Demonstration Projects*.

Additionally, the Children's Bureau, through its Office of Child Abuse and Neglect, administers nine state grant programs including: the *Safe and Stable Families* program. Following is a brief description of those programs that are most likely to support services for whole families affected by substance abuse. More information is available at the Children's Bureau website (www.acf.hhs.gov/programs/cb)

- The **Abandoned Infants Assistance** program provides grants to public and private entities to provide services designed to prevent abandonment or help achieve stability and permanency for children that are abandoned primarily due to HIV and/or substance abuse. The service interventions supported by these grants are extremely flexible, allowing programs to provide intensive, innovative, wrap-around services to whole families, including infants and young children, biological parents and siblings, extended family, and foster/adoptive families.
- The **CAPTA Research and Demonstration Projects** (formerly administered through the National Center on Child Abuse and Neglect, now at the Office of Child Abuse and Neglect within the Children's Bureau) provide support for research on the causes, prevention, and treatment of child abuse and neglect; for demonstration programs designed to identify the best means for preventing maltreatment and treating troubled families; and for the development and implementation of training programs.
- The **Safe and Stable Families** program encourages and enables states to develop, expand, and/or operate family preservation services, community-based family support services, time-limited family reunification services, and adoption promotion and support services. "Family preservation

services" typically are activities to assist families, including adoptive and extended families, at risk or in crisis. "Family support services" are community-based services that promote the safety and well-being of children and families, increase the strength and stability of families; strengthen parenting skills; afford children a safe, stable, and supportive family environment; and otherwise enhance child development. "Time-limited family reunification services" are services provided to a child that is removed from home and placed in a foster family home or a child care institution, and to the parents or primary caregiver in order to facilitate reunification of the child safely and appropriately within a timely fashion. These services include substance abuse treatment, mental health services, domestic violence services, and child care and crisis nurseries. Within these guidelines, states have broad discretion on how to use block granted funds.

Also under ACF is the **Office of Community Services** (OCS), which administers the *Community Services Block Grant*, *Social Services Block Grant*, and *Family Violence Program*. The office also funds discretionary grant programs that foster family stability, economic security, responsibility and self-support; promote and provide services to homeless and low-income individuals; and develop new and innovative approaches to reduce welfare dependency.

Office of Community Services

370 L'Enfant Promenade

Washington, DC 20447

Phone: (202) 401-5529

Fax: (202) 401-5718

Website: www.acf.dhhs.gov/programs/ocs

- The **Community Services Block Grant** program provides states with funds to provide a range of services to address the needs of low income individuals to ameliorate the causes and conditions of poverty. Services include employment, education, income management, housing, nutrition, emergency services, and health. States and tribes and territories must submit an annual application and pass through 90% of the funds to Community Action Agencies and other community-based organizations. The CSBG is administered by OCS' Division of State Assistance.
- The **Social Services Block Grant (SSBG)** is intended to prevent, reduce, or eliminate dependency; prevent neglect, abuse, or exploitation of children and adults; prevent or reduce inappropriate institutional care; and provide admission or referral for institutional care when other forms of care are inappropriate. Based on a formula, grants are made directly to states to fund social services tailored to meet the needs of individuals and families residing within that jurisdiction. State have complete discretion over the distribution and use of the funds.
- The **Family Violence Program** is designed to assist states in supporting the establishment, maintenance, and expansion of programs and projects to prevent incidents of family violence and provide immediate shelter and related assistance for victims of family violence and their dependents.

Additionally, ACF's **Office of Family Assistance** oversees the *Temporary Assistance for Needy Families Program* (TANF). This program was designed to provide assistance and employment opportunities for needy families, and states have broad discretion over how the funds are used to this

end. *Helping families achieve self-sufficiency: A guide on funding services for children and families through the TANF Program* can be found on-line at www.acf.dhhs.gov/programs/ofa/funds2.htm.

Finally, ACF conducts a **Fatherhood Initiative** (<http://fatherhood.hhs.gov>), which was designed to help low-income fathers obtain the skills they need to support their children. Currently, HHS, in partnership with a private initiative (Partners for Fragile Families), supports demonstration projects in ten states to provide employment, health and social services to involve fathers with their children and help mothers and fathers build stronger parenting partnerships. Also, through ACF's Office of Child Support Enforcement, eight states have received Responsible Fatherhood demonstration grants or waivers to provide a range of services to encourage more responsible fathering by non-custodial parents. While neither of these programs is designed specifically to address "partner" issues, they can be an excellent resource to provide direct, concrete services to partners, couples and families.

2. Substance Abuse & Mental Health Services Administration (SAMHSA)

SAMHSA, which includes the Center for Substance Abuse Treatment (CSAT), the Center for Substance Abuse Prevention (CSAP), and the Center for Mental Health Services, administers the bulk of federal funds available for substance abuse and mental health services. Many of the grants are time-limited, targeted to specific identified purposes or populations (e.g., women with co-occurring disorders), and involve a strong research component. Their website (www.samhsa.gov) provides information on all the available grants at any given time.

Center for Substance Abuse Prevention (CSAP)

Rockwell Building Two, 6th Floor

5600 Fishers Lane

Rockville, MD 20857

Phone: (301) 443-0365

Fax: (301) 443-5447

Website: www.samhsa.gov/centers/csap/csap.html

CSAP funds demonstration grant programs such as the Pregnant/Postpartum Women/Infants Demonstration Program, which supports models for serving substance abusing women and their young children.

Center for Substance Abuse Treatment (CSAT)

Rockwell Building Two, 6th Floor

5600 Fishers Lane

Rockville, MD 20857

Phone: (301) 443-5700

Fax: (301) 443-8751

Website:

www.samhsa.gov/centers/csat2002/csat_frame.html

CSAT administers a wide range of grants to private, community-based organizations and public local and state agencies to improve the provision of substance abuse treatment services to women, men, children and families. Various RFPs (request for proposals) are issued throughout the year. Some of them focus on a specific issue or target population, and others are more general and flexible.

Center for Mental Health Services (CMHS)

Parklawn Building

5600 Fishers Lane

Rockville, MD 20857

Phone: (301) 443-0001

Fax: (301) 443-1563

Website: www.samhsa.gov/centers/cmhs/cmhs.html

CMHS leads national efforts to demonstrate, evaluate, and disseminate service delivery models to treat mental illness, promote mental health, and prevent the development or worsening of mental illness when possible. The Center oversees a variety of service-related programs including the *Children's Mental Health Services Demonstration Program; Planning and System Development Program for Children; Clinical Training, Protection and Advocacy Program; Prevention and Program Development; and Human Resources Planning and Development Program*. The Center also administers the Mental Health Services Block Grant to the States.

3. National Institutes of Health (NIH)

NIH focuses on research to identify effective health interventions and services for specific population. Research programs related to children, youth and family issues are offered through various institutes including: the National Institute of Mental Health (NIMH), National Institute on Drug Abuse (NIDA), National Institute on Alcohol Abuse and Alcoholism (NIAAA), and the National Institute of Child Health and Human Development (NICHD). Program Announcements from any of these institutes can be found on the NIH website (<http://grants.nih.gov/grants/guide>).

National Institute of Mental Health (NIMH)

Parklawn Building

5600 Fishers Lane

Rockville, MD 20857

Phone: (301) 443-4513

Fax: (301) 443-8431

Website: www.nimh.nih.gov

NIMH supports research and research training programs to increase knowledge and improve

research methods on mental and behavioral disorders. The Institute supports Programs for Special Populations and Mental Health Education Grants. Programs, with a focus on mental health services for children, youth and families, and issues related to violence and traumatic stress.

National Institute on Alcohol Abuse and Alcoholism (NIAAA)

*Willco Building
6000 Executive Boulevard
Rockville, MD 20852
Website: www.niaaa.nih.gov*

NIAAA supports research and research training programs to develop new knowledge that will reduce the incidence and prevalence of alcohol abuse and alcoholism and reduce morbidity and mortality associated with alcohol abuse and alcoholism. NIAAA calls special attention to the need for studies focused on alcohol-related problems of women, infants, adolescents and youth, the elderly, and minority ethnic groups. Research grant programs have emphasized topics including the role of alcohol in intentional injuries, such as spousal and child abuse; alcohol use in pregnancy; and the relationship between childhood sexual abuse, abuse in adolescence, and sexual risk taking.

National Institute on Drug Abuse (NIDA)

*6001 Executive Blvd.
Room 5213
Bethesda, MD 20852
Phone: (301) 443-1124
Website: www.nida.nih.gov*

NIDA supports research and research training programs on all aspects of drug abuse and addiction, including the link between child maltreatment and

drug abuse. Past projects have emphasized the role of drug abuse in child abuse and neglect, intervention strategies to prevent child abuse, neglect and violence associated with substance abuse, and the role of child abuse, neglect, and victimization in the etiology, natural history, and consequences of drug use.

Department of Justice

*Tenth Street and Constitution Avenue NW
Washington, DC 20530
Website: <http://www.usdoj.gov>*

The Department of Justice funds programs addressing child abuse and neglect, domestic violence, services for crime victims, and prevention. The Department's **Office of Justice Programs (OJP)** publishes a topical guide, *At-A-Glance*, to all their funding opportunities. *At-A-Glance* (www.ojp.usdoj.gov/ocpa/ataglance) provides brief descriptions of funding opportunities, listing the amount of funding available, who can apply, and the status of program regulations, guidelines, reports, and application kits. Within the OJP are the Office for Victims of Crime and the Violence Against Women Office.

Office for Victims of Crime (OVC)

*810 Seventh Street NW
Washington, DC 20531
Phone: (202) 307-5983
Fax: (202) 305-2440
Website: www.ojp.usdoj.gov/ovc*

OVC administers formula and discretionary grants for programs designed to benefit victims, provide training for diverse professionals who work with victims, and develop projects to enhance victims' rights and services. A major responsibility of OVC is to administer the Crime Victims Fund, which

supports domestic violence shelters, children's advocacy centers, and rape treatment programs. Also, OVC manages the Children's Justice Act Grant Program, which awards grants to States and tribes to improve the investigation, prosecution, and handling of child abuse cases, and administers the Victims of Crime Act (VOCA) formula/block grant programs and victim assistance grants.

Violence Against Women Office (VAWO)

Office of Justice Programs

810 Seventh Street, NW

Washington, DC 20531

Phone: (202) 616-8894

Fax: (202) 307-3911

Website: <http://www.ojp.usdoj.gov/vawo>

The VAWO administers a variety of state formula and discretionary grant programs designed to develop and strengthen the criminal justice system's response to violence against women, and to support and enhance services for victims

Department of Housing and Urban Development (HUD)

451 Seventh Street SW

Washington, DC 20410

Phone: (202) 708-1112

Website: www.hud.gov

Within HUD, the Office of Community Planning and Development (CPD) offers a number of programs that address homelessness, which frequently co-exists with AOD problems. A major component of CPD is the Community Development Block Grant (CDBG) Program, which provides grants and loans to public and private agencies to

support a wide range of community development activities. In addition, CPD administers the Empowerment Zone and Enterprise Community (EZ/EC) Initiative, Shelter Plus Care, Emergency Shelter Grants, and Safe Havens Innovative Homeless Initiatives Demonstration Program. HUD also administers the Section 8 program, and various other housing programs for families with low income or other special needs.

Model Programs

The following profiles characterize several programs around the country that have successfully treated women affected by AOD and their partners. These programs offer a range of services and serve as models for integrating different service and treatment components for women affected by AOD, as well as their partners and children. Program descriptions were created from phone interviews with program directors and other staff members, symposium presentations, and written program materials.

BIENVENIDOS FAMILY SERVICES

East Los Angeles, California

History and Mission

Bienvenidos Family Services uses a multi-disciplinary, inter-organizational, culturally sensitive approach to provide comprehensive services for families of infants and young children at-risk of being abandoned due to substance abuse or HIV. Their primary goal is to prevent child abuse and neglect and provide families with the tools to be a productive family. Located in East and Southeast Los Angeles for 15 years, Bienvenidos serves a large Latino community and, therefore, offers all services in English

and Spanish. Virtually all of the families served by the program are affected by substance abuse, and most are affected by poverty, isolation, unemployment and poor job skills, and a history of domestic violence and/or childhood abuse. Although initially the program only served mothers and children, they learned that approximately half of the women are married or have domestic partners, and many have a history of unstable relationships. Therefore, the program is strongly committed to addressing the needs of whole families including fathers and young men. As the program has evolved to better meet the needs of partners and fathers, so too has the staff, which went from almost all female to 40% male.

Services

In their 15 year history, Bienvenidos has served over one million individuals. The spectrum of services is broad and tailored to fit the needs of each individual client. Specific services include in-home family assessment and support services, outpatient treatment for women and their children, crisis respite care, health education, health and mental health services for men and women, recovery support and 12-step programs for men and women, parenting classes for men and women, couples and family

therapy, domestic violence classes, self-esteem and life skills workshops, literacy classes, crisis intervention, and job development. Many of these services are available to all family members including fathers and partners, and transportation and free childcare are offered during all center-based services. Additionally, male partners of women in treatment can receive free services through Bienvenidos' Latino Fatherhood Program, which is designed to reinforce fathers' positive involvement in the lives of their families and community. Classes offered include: anger management, male involvement groups, fatherhood classes, and a Compadres Network. Bienvenidos also offers a peer-run alumni group for women who have completed the outpatient treatment program. The group focuses on strengthening support, recovery maintenance, strengthening life skills, and building positive relationships.

Although Bienvenidos has a tradition of creating more services as the need arises (e.g., establishing a men's health center and a fatherhood program), they continue to collaborate with other agencies to complement their already comprehensive services. For instance, they have established linkages with various legal service providers and organizations that offer free legal services on behalf of children's rights, immigration, housing, discrimination, and public entitlement matters. The program also collaborates informally with dozens of substance abuse and HIV programs in the area, and refers families to several community mental health agencies for more intensive services.

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THE VILLAGE: FAMILIES IN TRANSITION

Miami, Florida

History and Mission

Families in Transition (FIT) was created in 1992 using funds from the Substance Abuse and Mental Health Services Administration (SAMSHA). The goal of FIT has remained the same throughout its existence: to help women by involving the entire family in a broad array of treatment services that focus on recovery and relapse prevention. FIT is a residential program that is very family and couple focused. It is one of the few residential treatment programs that permits couples—and entire family units—to reside in treatment together. Their target population is “any substance abusing woman, man, or couple who have children.” Many of their clients are involved with the child welfare system and reliant on public assistance (i.e., TANF). Originally designed as a 12-month program, the current length of stay averages about 5-8 months.

Services

In their comprehensive approach, FIT offers numerous services designed to address the multiple needs of families affected by AOD addiction. The substance abuse treatment is based on a step down approach, with an intensive in-patient component as the first phase. Recognizing that female addicts frequently have violent histories, they do not use confrontational techniques. Thus, participants are exposed to a nurturing and empowering

environment that emphasizes peer support, guidance, modeling, individual and group responsibility, and relationship building. Partners are welcomed into the residential setting and portions of the treatment program (e.g., conflict management) are geared specifically toward the couples. Additionally, children are allowed to reside in treatment along with their parents. The children's needs are addressed through the provision of childcare and mental health and physical assessments. A Head Start program is also housed at FIT. Finally, FIT provides aftercare services that include twice weekly group therapy for 1 year following graduation from the residential program. Child care services are provided for an additional year post graduation.

FIT can accommodate 30-35 families at one time. Approximately 5-6 of these families are couples. FIT can also accommodate teenage mothers. At any one time, there are about 50 to 60 children residing there with one or both parents. There are no limits on the number of children allowed per family, nor are there any formal age requirements for the children. However, it has been difficult for teenage children to live in the residential program.

FIT employs a broad staff. Social workers provide case management services and much of the therapeutic support. In addition, there are on-site clinical psychologists, nurses, physician assistants, psychiatrists, and child development specialists. In addition to FIT, The Village also offers separate residential and outpatient services for women, men, women with children and adolescents. They also have a collaborative relationship with University of Miami where they refer clients who need more formal mental health treatment.

Contact

- The Village
Families in Transition
3180 Biscayne Blvd.
Miami, FL 33137
Ph: (305) 571-5526 or (800) 443-3784
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PROJECT NETWORK: COUPLES GROUP

Portland, Oregon

History & Mission

In 1996, the treatment team at Project Network, a residential program for women, modified their program to address the ways that their female clients sabotaged their own recovery process. More specifically, the team recognized that women frequently left treatment prematurely and re-engaged in risky and unhealthy relationships with previous or current partners. From the perspective of the treatment team, the "women prioritized relationships, regardless of their harm, over their own sobriety." Thus, the team collaborated with the Department of Adult Community Justice (DACJ) to develop a couples component, "Couples Group," to reach out and engage the partners of their female clients in treatment to address the issues pertinent to their relationships. Project Network and the Couples Group serve a broad population of women and their partners. While most of the women participating are court mandated and involved with the child welfare system, these are not requirements. The programs are geared toward adult women, though some 17 and 18 year old women have participated. Also, while the vast majority of the partners are men under community supervision (e.g., parole/probation), women and male partners without criminal justice involvement are also welcome and do participate.

Services

Project Network is a one-year residential program for substance addicted women that focuses on helping women transition back to the community. Services include 12-step and relapse prevention, case management, mental health and domestic violence assessments, referrals to other agencies and services (e.g., mental health and/or individual couples counseling), and outreach to the criminal justice system. The program is designed in three phases. Phase 1 is a 30-day black-out period in which residents are not allowed contact with people outside the program. During Phase II, women begin to deal with relationship issues and other factors affecting their recovery; and Phase III focuses on re-entering the community.

During the assessment period in Phase 1, women are asked about their significant others and relationship issues. If they identify a current partner, a parole officer/case manager at the DACJ begins to engage the partner and invites him or her to attend a partners group to help prepare them for the couples group. When women enter Phase II, they and their partners are invited to attend couples group. The group is co-facilitated by a female MSW level counselor and a male parole officer. It is designed as a 14-week program where 10 couples meet for three-hour sessions once per week. Although it is based on a structured curriculum, women often informally set the agenda by raising issues that they want to discuss. Program staff state that the clients gradually become comfortable in disclosing their personal experiences as they pertain to the group's curriculum. More than two-thirds of the women involved in Project Network participate in Couples Group, and their partners have a 90% attendance rate at Group. The relationship-based curriculum emphasizes the dynamics of intimacy, sexual relationships, parenting, domestic violence, communication, and family struc-

ture and unity. Program staff note that one central family issue that often arises for the male participants is their resistance and anger around caring for non-biological children of their female partners.

Additionally, individual couples therapy and case management services for the partners are available; and some couples are able to co-habitate at the residence for one year after the woman completes her treatment.

Contact

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Or
Olivia Jeffries
Project Network
Ph: (503) 528-2153

OKLAHOMA INFANTS ASSISTANCE PROGRAM

Oklahoma City, Oklahoma

History & Mission

The Oklahoma Infants Assistance Program began in 1996 as a treatment program for substance abusing mothers of young prenatally drug exposed children. Referrals come from juvenile judges and child welfare workers, with court referrals comprising 98% of the client base. The program's mission is to reduce the amount of time that children reside in the child welfare system and to help their clients clarify

their reunification timeline and prospects. Specifically, the program helps clients decide whether to get clean and sober and make changes in their lives necessary to reunify with their children, or to continue using and voluntarily relinquish their parental rights. A couple of years ago, recognizing that fathers not only have parental rights but play a large role in the women's ability and desire to become and remain clean and sober, the program began to actively seek the inclusion of the children's fathers into the treatment program. The program has the capacity to serve 25-30 women, along with their children and partners, who are primarily, but not exclusively, male. Services are provided by MSW and Ph.D. level clinicians.

Services

This one-year, family-focused outpatient program attempts to involve entire family units in order to assess the desirability and likelihood of reunification. Services include in-home counseling and case management, and parent-child interaction therapy. For mothers, treatment components emphasize substance abuse education and relapse prevention and the facilitation of healthy relationships and include education about domestic violence and relationship skills building groups. Male therapists facilitate separate group therapy sessions for the men/fathers. Similar to the women's therapy format, the topics of these groups include parenting, life and relationship skills, and substance abuse education. The male participants also may elect to enroll in individual substance abuse counseling. Additionally, the program offers couples counseling and provides in-home follow-up services for two months following graduation from the program.

Contact

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PALLADIA, INC.: FAMILY SUPPORT SERVICES PROGRAM

New York, New York

History & Mission

Palladia, Inc. (formerly Project Return) has a 30-year history of serving individuals and families affected by substance abuse, homelessness, mental illness and domestic violence. In 1998, they created a new program specifically geared toward engaging the family members of mothers and fathers, who are involved or at risk of involvement in the child welfare system and receive substance abuse services through Palladia. While the client resides in the treatment program, the Family Support Services Program (FSSP) provides support services to grandparents, relatives, partners and other caregivers (e.g., fathers) of infants and young children at risk for abandonment by the client in treatment. MSW level staff provide the services, which focus on rebuilding trust and safety between family members.

Services

Palladia's Starhill Facility includes four separate modified therapeutic communities in which, each

year, 417 women (40%) and men (60%) receive intensive, short-term AOD treatment for 6-12 months. The FSSP attempts to involve caregivers of the children, who often are the other parent, in the mother's or father's treatment in order to promote a commitment to continued substance abuse treatment and foster caregivers' support for treatment. To this end, the FSSP offers agency-based and home-based, relationship-focused services, which involve other family members. After a 30-day black-out period, residents participating in FSSP receive individual counseling and monthly support groups that focuses on relationship and parent skills building, as well as coping and effective communication skills. The program also offers the caregivers (most of whom are the other parent) individual counseling, as well as education on how to relate to an individual with a substance abuse problem. Additionally, FSSP offers couple and family therapy, as well as monthly family outings, which are supervised activities provided outside of the agency to help family members re-establish connections and practice being a family again. Involving family members not only helps rectify relationship wounds, it also creates a support network for the clients in treatment and helps to motivate them. Given that most of the children of parents involved in the program are seven years old or younger, another primary goal of the program is to promote stability and permanency for these children. To this end, the program also offers an Active Parent Group and a bi-weekly support group for fathers. The fathers group focuses on their role as fathers and their relationship with the mother of their children, as well as relationships with women in general. Finally, the program provides six months of follow-up care to entire families following treatment.

Contact

- Family Support Services Program
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Bronx, NY 10453
Ph: (718) 299-3300
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Email: info@palladiainc.org

MILWAUKEE WOMEN'S CENTER

Milwaukee, Wisconsin

History & Mission

The mission of the Milwaukee Women's Center is to research, develop, and implement programs that end all types of abuse and violence toward women and children. While the Center (MWC) began as an emergency shelter for battered women in 1980, the needs of the original target population thrust the MWC into the business of providing services to address the underlying causes and consequences of domestic violence including substance abuse and other systemic issues. Currently, the Center provides services to approximately 2,000 men, women and children annually. The majority of individuals served are Milwaukee-area residents, 80% of whom live near or below the poverty level.

Services

Throughout all programs and departments of the MWC, case managers employ a strength-based model of case management that incorporates the stages of change. This strength-based model is based on the belief that clients will be most successful when they focus on their strengths and are meaningfully involved in directing their own treatment.

MWC employs a multi-disciplinary and culturally diverse staff to provide the following services: an emergency domestic violence shelter for women, who need not be abstinent, and their children; a crisis hotline; a behavioral health clinic; an older abuse women's program; a central intake unit for the public-private TANF project; case management services for families; community education and outreach; various services for women who abuse substances; support services for men who batter; and a fatherhood program. MWC's *Positive Options for Women Entering Recovery* (POWER) program is divided into three phases. Phase I, crisis management, focuses on assessment, safety, and relationship building. During this phase, clients are expected to attend two groups per day, and at least one face-to-face meeting with the case manager and one home visit per week. Phase II focuses on stabilization, parenting skills, and compliance with legal and child welfare conditions. Phase III focuses on independence, relationships, re-entry to the community, and other long-term goals, with services provided on an individualized, as-needed basis. Women stay in the program for up to two years and are followed for an additional year after graduation.

In addition to couples and family counseling, MWC provides family-focused, home-based case management and relapse prevention services, and a variety of mental health services are available to all family members through MWC's Behavioral Health Clinic. Finally, specific services for partners, men and fathers include a Fatherhood Program, which provides group and case management services, and NEVERMORE, a 20-session group therapy/education program for treating physically, verbally and/or psycho-emotionally abusive behaviors in men.

Contact

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JELANI INC.

San Francisco, California

History & Mission

Jelani Inc. opened its doors in 1990 with the intention of treating crack-addicted pregnant women. Over the past 12 years, as the substance abusing population has changed, this umbrella organization has evolved into its current format containing five distinct substance abuse treatment programs that treat women, men, couples, and families affected by chemical dependency:

Jelani House is a 16 bed perinatal program for pregnant and parenting women with AOD addiction. The residents are allowed to bring up to two children under the age of 5 years in addition to a baby, and they may reside there for one year. Services focus on AOD treatment, obtaining housing, parenting skills, case management and prenatal care. An on-site preschool and child care are also provided.

Jelani Out-Patient is an outpatient program that can serve up to 75 clients for 6 months. The program also provides pre- and after-care for individuals waiting to get into or coming out of one of Jelani's residential programs. Services are for both men and women.

From Start to Finish is a 6-9 month residential program solely for men, particularly those who have had, or are at risk for having, criminal involvement. The sheriff's department is a referral source for this program.

Rights of Passage is 24-bed program for pregnant and parenting women and their children under 12 years of age. Funded through CALWorks, the program provides residential substance abuse and mental health treatment services, with a focus on domestic violence, employment, housing, and family resiliency.

Newhall Manor is 6-9 month residential treatment program for families. With 16 beds in four dorm-style rooms, it is specifically for hererosexual or homosexual couples with children, or for single male or female parents with children. Most of the families are referred by child protective services.

The overall mission of these programs is to help clients get clean and sober.

Services

The services offered at the respective programs vary according to the specific population being served. All of the programs, however, thoroughly assess the clients' trauma history, and they all focus on recent traumatic events and relationship issues. Jelani Inc. operates under the philosophy that the client's partner is an integral aspect of a woman's recovery. Thus, they have determined that it is important to involve the partner from the very first day of treatment so that the partner will feel included and engaged throughout the process.

In addition to intensive substance abuse treatment, the programs also conduct group therapy sessions for individuals and couples, as well as life and parenting skills training and anger management

classes. The programs partner with a number of local mental health providers and refer clients who need intensive mental health counseling and/or domestic violence intervention. Additionally, one therapist from a local mental health agency is out-stationed at Jelani House to provide mental health services to women, men, children, couples and families involved in any Jelani programs. Participants also engage in a number of ongoing clean and sober recreational activities sponsored by the program and are strongly encouraged to build up their support network outside of Jelani, e.g., join AA and NA and develop friendships away from the program. Finally, most clients receive one-year follow-up services.

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LA BODEGA DE LA FAMILIA

New York City—Manhattan's Lower East Side

History & Mission

Founded in 1996 as a demonstration project of the Vera Institute of Justice, La Bodega de la Familia is a community-based program that engages and supports the families of drug users under community-based justice supervision (pretrial, parole, and probation). La Bodega's goals are: (1) to improve community-based drug treatment outcomes; (2) to

reduce the use of arrest and incarceration in response to relapse; and (3) to reduce harms that substance abuse causes within families.

Working out of a storefront on Manhattan's Lower East Side, La Bodega's bilingual staff are deeply committed to the residents of the community they serve. Applying an innovative model called Family Case Management (FCM), La Bodega brings together the substance user, family member(s), supervising agent, and a La Bodega family case manager to develop an action plan for working together. Using the FCM model, participants are urged to look for each other's strengths, rather than their weaknesses; to look to their extended families and to the community for additional resources that might be needed; and to build relationships of trust and respect among all members of the team.

Among the tools of FCM are the *family assessment*, which identifies the families needs and capacities; the *ecomap*, which charts the many government and community systems—sometimes conflicting—with which a family must deal; the *genogram*, which shows where the strengths and resources of a family reside; and the *action plan*, which sets a course of action for each member of the team.

Although the program is open to any individual or family meeting its criteria, family case managers do require that at least one significant other is involved in the recovery process, and they strongly encourage the inclusion of multiple family members. This significant other is defined by the client and may be a partner, spouse, or parent; it may also be a neighbor, friend, or a community resource such as a priest or minister, or a counselor.

La Bodega's family-focused interventions aim to minimize contributors to relapse and to enhance positive factors that promote a healthy substance-free lifestyle. The program is also geared toward reducing

the secondary effects of AOD use, such as HIV infection, domestic violence, and youth violence. To this end, La Bodega offers 24-hour support services for drug-related emergencies.

Since its founding in 1996, La Bodega has served more than 800 families using its FCM approach, with the capacity to serve 125 families at any given time. The majority of participants referred to La Bodega by probation or parole are male; approximately 10 percent are female. Given the large Latino population residing in La Bodega's catchment area on the Lower East Side, the vast majority of participating families are Latino.

Services

La Bodega offers numerous services that aim to improve family and interpersonal functioning. La Bodega is a strong believer in cultivating—or building upon—support systems for participants as a mechanism for recovery. Based on the premise that the family system may be the best opportunity to support treatment and community supervision mandates for the drug user, family members are encouraged to be active participants from beginning to end. If the participant's partner has, for example, an immediate health need, La Bodega works with a local health provider to facilitate treatment.

In addition to La Bodega's FCM services, many more individuals and families take advantage of La Bodega's other services, which include a variety of support groups, referral services to other social service agencies, and many educational and cultural activities for young and old alike. In keeping with the community-oriented spirit of the agency, neighborhood projects (e.g., community gardens, mural projects, and after-school projects) are organized by and for the substance abusers and their families.

Strong partnerships with parole, probation, police, and a host of community-based, social service and health organizations contribute to La Bodega's success and are, in fact, organizing principles of the program. One example is La Bodega's unique partnership with Parole, where four full-time parole officers and a parole supervisor are assigned to work exclusively with parolees through La Bodega.

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WOMEN IN NEED: ALCOHOL AND SUBSTANCE ABUSE TREATMENT CENTER & CASA RITA SUBSTANCE ABUSE TREATMENT PROGRAM FOR WOMEN

Manhattan & Bronx, New York

History & Mission

The Women in Need (WIN) program is dedicated to serving the comprehensive needs of homeless women and their children. Falling under this umbrella organization are two programs specifically for substance abusing women: Casa Rita in the Bronx and the Alcohol and Substance Abuse Treatment Center in Manhattan. Utilizing family-oriented treatment protocols, WIN has been providing substance abuse treatment for 16 years. Each program has the capacity to treat 150 women per year,

and the capability to provide child care for the women's children.

Composed of homeless and disadvantaged women, the demographic make-up of the clients is as follows: 70% are receiving TANF; approximately half have not completed high school; a substantial number are involved with the child welfare system; and at least half are afflicted with mental health diagnoses, as well as histories of childhood sexual abuse. Moreover, the client population is quite diverse (African American 65%; Latina 25%; Caucasian 4%) with the average age being 34 years old. Outreach efforts to the lesbian population have been successful, with 15% of their client group composed of lesbians. Finally, staff report that rates of domestic violence are very high among their clients.

Services

Although the services do not involve outreach to the clients' partners, the programs have adopted a relationship-focused paradigm that underscores their service delivery. Licensed by the NY State Office of Alcohol and Substance Abuse Services, the two programs offer comprehensive treatment packages designed to meet the breadth of needs of their clients. Women clients are provided with the following:

- **Physical health services** such as physical exams, health and sex education classes, and referral for STDs and HIV.
- **Mental health services** overseen by psychiatric staff.
- **On-site therapeutic child care** for infants, toddlers, and school aged children. In addition to structured child care, mental health screenings and parenting courses are also offered.

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- **Nutrition services** including nutrition classes and daily breakfast and lunch which help instill a community environment for the clients.
 - **Vocational education** classes are provided to the women to help them learn job skills along with employment and hiring techniques.
 - **Domestic violence services** consist of both group and individual sessions run by counselors trained in DV. By distinguishing the group as focusing on "safety and sobriety" instead of specifically on DV, the counselors are able to enroll a large percentage of the clients. The groups focus on education about safety in relationships, counseling to facilitate the decision making process, and referrals to more intensive individual treatment.
 - **Individual and group therapy** that centers on relationship issues, trauma, childhood abuse, and chemical dependency. For example, women may enroll in ongoing weekly group treatment sessions that focus on healing and recovery. Treatment entails both education and dynamic process issues pertaining to interpersonal relations. Referrals to local private therapists are offered to women who are in need of such services.

Finally, after care services, which encompass weekly group therapy meetings and monthly individual sessions are offered so that the women can stay connected to the program while they transition to independent living.

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Conclusion and Future Directions

For this monograph, we have synthesized a vast array of information provided by TEG members, literature, and program directors across the country in an attempt to highlight the complexities faced by women in recovery, as well as to emphasize the micro and macro level needs of creating adequate services for this population. In drawing together the disparate perspectives for this report, we have come away with clear indications of the direction that the field—from direct service practitioners to researchers and policy makers—must take in order to ensure effective, long-lasting treatment services for women with AOD difficulties.

At the heart of this monograph is the premise that women recover in partnership with others, not in isolation. Capitalizing on the strengths of partners, family members, and local community residents is vital to sustaining healthy recovery in women. As one program director states, "families are a hidden and underutilized resource in the recovery process." Furthermore, as discussed throughout this text, women's AOD difficulties are often rooted in a history of traumatic events. These traumatic histories may then engender a persistent pattern of psychological impairments and poor psychosocial functioning, particularly with respect to women's capacity for

building loving, trusting, and intimate connections with others. Female addicts' are predisposed for revictimization, and domestic violence occurs at alarmingly high rates in this population.

The role that partners play in the addiction and recovery process has not been extensively studied or understood by the field. Based on testimony by TEG members and on the limited empirical documentation that has been done in this area, we know that partners often purposely or unwittingly play a large role in women's introduction to substance use. Just as importantly, partners can exert substantial influence, both subtly and explicitly, on women's recovery process. While some of this negative influence may be attributable to partners' fears and sense of shame about women's AOD use, some partners are contending with their own AOD difficulties and may also be in critical need of services and treatments. Thus, in order to help support women in their recovery, it is critical to address the roots of their substance abuse and the nature of their relationships, and to include their partners in the process and address the partners' concrete and psycho-social needs.

Moving the field forward to provide coordinated, truly family-focused services requires broad,

policy level changes, as well as modifications in the implementation of services at the local level. As discussed throughout this monograph, **providing gender-specific services** that comprehensively address the interdependence of addiction, trauma, and psychopathology among female addicts is essential to the long-term health of substance abusing women. Similarly, **using a family systems and/or integrated family-focused treatment** approach will help female addicts uncover their unhealthy relationship patterns and provide them with healthy support networks as they navigate recovery. For example, we noted several programs that offered innovative services such as providing residential treatment to couples with children and/or incorporating family activities into the treatment regimen.

It also is important to **develop methods for assessing and engaging partners in the treatment process**, both for the health and safety of the woman, but also to facilitate the partner's own recovery process. This involves being aware of and sensitive to the cultural, societal, and emotional reasons that may preclude men's participation in treatment. Female partners may possess a unique set of reasons for avoiding treatment in that they may sense a program's hesitancy to treat lesbian clients and/or be wary of treatment components for partners (e.g., partners' groups) that may be almost exclusively composed of males. Similarly, it is incumbent upon agencies and treatment programs to **provide the partner with services directly or through referrals to outside agencies**, and to offer relationship-focused services for both partners. As noted in the monograph, several agencies arrived at the pragmatic realization that women were going to surreptitiously return to their current, oftentimes substance abusing, partners regardless of their own progress in treatment. Thus, in order to divert the women from

sabotaging their recovery, the programs decided to open their doors and invite the partners to become involved. This approach has been quite successful in numerous locations.

Because women and their partners may have multiple systemic issues (e.g., domestic violence, child welfare involvement, unemployment, housing) underlying and affecting their recovery process, **agencies need to contain—or have access to—multifaceted treatment components** that can serve all of the diverse needs of the clients. For example, it may be necessary to forge partnerships with the criminal justice system and/or agencies focused on domestic violence so that these needs can be addressed.

It also is **necessary to provide ongoing training and supervision to staff members**. Conducting front-line services to substance abusing clients is demanding in and of itself. Creating and providing services to clients' partners may be all the more taxing in that it may require a paradigm shift on behalf of the treatment providers. Thus, this modification in the treatment modality will necessitate the close monitoring of providers' countertransference and other personal reactions to this change.

On a broader systems level, **incorporating program evaluations into the program framework** will be essential if the field wants to fully understand and assess service delivery components that work for these individuals and families. Evaluations can serve numerous purposes. For instance, information gathered through a carefully designed evaluation can facilitate program improvements and justify ongoing or new funding. Understanding the strengths and weaknesses of program models, staffing procedures, and client outcomes are also all measurable components of evaluations.

Finally, at the federal, state, and local policy level, **collaborative efforts among policy makers** are

essential for moving the field toward integrated and holistic services. This must be done through flexible, integrated funding streams. Additionally, there must be programmatic recognition of the role that partners and fathers play in women’s recovery and children’s well-being, and the inter-connections between substance abuse, child welfare, mental health, domestic violence, and criminal justice.



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Appendices

