CHAPTER FOUR

DRUG- AND ALCOHOL-ABUSING WOMEN

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Substance abuse is one of the most common psychiatric problems affecting women. There are millions of adult women in the United States addicted to mind-altering substances, including legal and prescription drugs such as alcohol, Valium, and other sedating benzodiazepines and opiate-type pain relievers; and illegal substances such as marijuana, heroin, cocaine, amphetamines, PCP, and the contemporary "rave drugs" such as ecstasy. According to the National Comorbidity Survey (Kandel, 1998), 6 percent of women ages fifteen to fifty-four meet the lifetime criteria for illicit drug dependence. Among pregnant women, sixty-two thousand (2.3 percent) used an illicit drug during the last month, 584,000 used alcohol (20 percent), and 591,000 (21.5 percent) used cigarettes. Millions of women are addicted to nicotine. "Thirty-one percent of women who have ever smoked meet the criteria for dependence" (Kandel, 1998, p. 25).

The impact of drug addiction is enormous. Under the influence of drugs, women lose their spouses, their jobs, their children, and their lives. Women are being incarcerated at increasing rates for drug-related offenses (Snell & Morton, 1991); alcohol and drugs are implicated in the crimes of 80 percent of incarcerated women (National Center on Addiction and Substance Abuse at Columbia University, 1998). In addition, the rate of women's driving under the influence of alcohol is increasing (Lex, Goldberg, Mendelson, Lawler, & Bower, 1994), and there are more drug-related cases of child abuse and neglect (Bays, 1990).

O'Connor, L.E., Esherick, M., & Vietan, C. (2002). Drug and alcohol-abusing women. In Straussner, L.S. & Brown, S. (Eds), The handbook of addiction treatment for women. San Francisco: Jossey-Bass.

Addiction to alcohol and other drugs (AOD) affects a broad spectrum of women from all socioeconomic and cultural backgrounds. The results of several national surveys demonstrate that across class and ethnicity, women outside traditional social roles, such as marriage or employment, have significantly higher rates of female drinking (Wilsnack & Cheloha, 1987). Surveys of ethnic differences in drinking reveal that among three major ethnic groups, White women are most likely to drink, African American women are least likely, and Hispanic women are in between (Caetano, 1991; Herd, 1998). In this chapter, we discuss factors that lead women to drug addiction, and we describe the immediate and long-term effects of various substances. This chapter also presents issues related to the assessment and treatment of women addicted to AOD.

Etiology of Addiction

Many women experiment with alcohol and drugs during their high school and college years, although some, particularly those women who grew up with AOD-addicted parents or siblings, begin sooner. A period of experimentation is considered normal, and there is some indication that adolescents who abstain from all substances are more likely to suffer from emotional problems (Shedler & Block, 1990). Most adolescent girls limit their experimentation with drugs to occasional recreational events. However, for a variety of reasons, some young women are particularly vulnerable to the effects of AOD, to escalating substance use, and to addiction. Some women who are able to limit their adolescent drug experimentation may develop serious drug problems at middle or older ages, frequently in response to marital or family difficulties, illness, or other stressful life events. Often this later-onset drug abuse involves prescription drugs, legally obtained through physicians or psychiatrists. Iatrogenic addiction—that is, addiction caused by medical practice—is an enormous problem for women (Hughs, 1976). However, the full extent of iatrogenic addiction is well hidden, and reliable statistics are not available. Women suffering from prescription drug addiction are often at risk for alcohol abuse. For example, a woman who has become addicted to benzodiazepines may need to increase her dosage in order to avoid withdrawal symptoms. Unable to obtain more of her legal prescription, she may resort to alcohol as a substitute. As is true of adolescents, middle-aged or elderly women vary in their vulnerability to addiction.

Biological and Genetic Factors

Vulnerability to addiction begins with a woman's biology. Biological differences among women affect their response to drugs; women may differ in drug metabolism, how pleasant they find the drugged state to be, and how quickly they get

addicted. For example, when prescribed an addictive medication (for example, Valium, Xanax, Ativan, Klonipin, Vicodin, or Percodan), a woman with a family history of substance abuse is likely, as a result of a genetic vulnerability, to rapidly develop tissue tolerance (the need to take more of the medication to achieve the same effect) and addiction. In contrast, a woman with no family history of substance abuse may be able to take an addictive drug for several months before becoming addicted. Thus, biological factors may be the primary cause of some women's addiction.

A discussion of the genetics of addiction necessarily focuses on the drug alcohol, as most of the research to date has been on alcohol dependence. Since the time of ancient Greece, the observation that alcoholism tends to run in families led observers to suspect that it was inherited. Family studies have confirmed this observation by noting that first-degree relatives of alcoholics are three to five times more likely to develop alcoholism than the general population (Schuckit, 1999). However, this fact alone does not prove that genetics play a role, as families share environment as well as genes. One way to address the question of nature versus nurture in the development of addiction has been through twin and adoption studies. Identical twins adopted apart at birth provide the best situation for studying the relative contributions of genetics and environment, because they share all of their genes and none of their environment. This situation is rare, however, so twin studies often use the behavioral genetic method of comparing identical twins and fraternal twins. Identical twins share all of their DNA, whereas fraternal twins share an average of 50 percent of their genes. If a trait is genetically influenced, identical twins should share it more often than fraternal twins. This is the case in alcoholism: identical twins are more likely to share drinking patterns than fraternal twins. Adoption studies allow researchers to look at individuals born to alcoholic parents but adopted into nonalcoholic households. Children of alcoholics have a higher risk for alcoholism, even when adopted into a nonalcoholic family (Goodwin, Schulsinger, Hermansen, Guve, & Winokur, 1973; Goodwin et al., 1974; Hesselbrock, 1995; Cadoret, O'Gorman, Troughton, & Heywood, 1985).

The extent to which genetics influence women's vulnerability to alcoholism has been questioned. As is the case in other areas of medical research, women are underrepresented in studies on the genetics of addiction, but this is gradually being rectified. Reviews of the literature have suggested that across twin and adoption studies, support for the genetic influence on alcoholism is strong in men and variable in women (George, 1997; McGue, 1993). In early family studies of alcoholism, Cotton (1979) reported that 20 to 25 percent of sons and brothers of alcoholics become alcoholics, but only 5 percent of daughters and sisters. However, there are not sufficient data to rule out equal influence of genetics in women's vulnerability to addiction (Hill & Smith, 1991). In fact, Hill (1993, 1995) reported that rates of alcoholism in relatives of female alcoholics were higher than for those of male alcoholics.

Analyzing Swedish adoption study data, Cloninger, Bohman, and Sigvardsson (1981) contributed to the view that alcoholism in women is less influenced by genetics. These researchers classified alcoholics as one of two types. Type II alcoholism was termed *male-limited* or familial alcoholism, and was characterized by a higher severity, earlier age of onset, and comorbid antisocial personality traits. Type I alcoholism affected both men and women, had a weaker familial component, and was characterized by a later onset and comorbid depressive and anxious traits. More recent research has proposed that these subgroups exist among women: an early-onset, high-severity group and a later-onset, lower-severity group, with the former exhibiting a higher influence of genetics (Hill, 1993).

The lower rate of alcoholism in women, as well as difficulties with the definition of the disorder, may have confounded earlier studies. Recent studies have provided evidence that similarly for men and women, genetics seem to account for about half of the vulnerability to addiction, and environment the other half (Kendler, Heath, Neale, Kessler, & Eaves, 1992; Pickens et al., 1991).

The vast majority of studies on the genetics of addiction have focused on alcoholism, but a few recent studies have examined other drugs of abuse. Kendler and Prescott (1998) studied cocaine and marijuana use in 1,934 pairs of female twins. They concluded that family and environmental factors were more influential in determining whether a woman began using drugs, but genes were largely responsible for whether she progressed to abuse or dependence. They estimate that genetic factors account for 60 to 80 percent of the difference in abuse of and dependence on marijuana and cocaine between fraternal and identical twin pairs, suggesting that abuse and dependence are in large part heritable. Similarly, when examining the genetic and environmental factors influencing women's use and abuse of hallucinogens, opiates, sedatives, and stimulants, Kendler, Karkowski, and Prescott (1999) found that genetic factors alone accounted for twin resemblances in the use of opiates, sedatives, and the abuse of stimulants, while both genetic and familial factors contribute to twin resemblances in the use of hallucinogens and the nonabusive use of stimulants. As for the drug nicotine, a recent National Institute on Drug Abuse report (Zickler, 2000) suggests that for women, the genetic contribution is significantly greater than for men.

The fact that both genetics and environment contribute to the development of addiction in women has significant clinical implications. Women most often come into treatment blaming themselves for everything, including their addiction (Inaba, Cohen, & Holstein, 1997; O'Connor, Berry, Inaba, Weiss, & Morrison, 1994; Straussner, 1997). These clients find education about the genetic component of addiction reassuring: it helps explain both the power addiction has over their lives and their continued use of drugs despite grave consequences. Similarly, psychoeducation about the role of genetics in addictions and other mental dis-

orders can help women come to terms with dysfunction in their families. Knowing that there is a biological basis to addictive patterns in their families helps women understand some of the underlying reasons for abusive or neglectful behavior from their family members, and it mediates the feeling that they did something wrong to deserve the abuse or neglect they experienced.

In the future, genetics and neuroscience may play a more direct role in treating drug addiction in women. By identifying the particular biological abnormalities that underlie craving, tolerance, and withdrawal, there may be problem-specific medical or psychosocial treatments that ease the process of withdrawal and recovery. It is possible that these medical interventions will be particularly useful for that portion of the population with whom our best efforts fail: women who have tried many avenues to recovery yet continue to have difficulty maintaining a drug-free state.

In addition, genetic testing may someday be available to estimate addiction risk. Although testing carries with it a host of ethical problems, it may be useful in assessing the risk for vulnerability, and contribute to prevention efforts.

Sociocultural Factors

In addition to having a possible biological vulnerability, some women may also have sociocultural predisposing factors. Young women who are unable to pursue age-appropriate developmental goals and ambitions (such as successful work) because of poverty, racism, sexism, or other factors that limit opportunities may find the drugged state attractive. Limited by social and economic conditions, they may find hanging out with their peers, taking drugs, and socializing their only pleasurable structured and social option. At an age when more fortunate young women are studying for careers and carefully planning for future families, women who grow up in settings with limited horizons may use drugs as a kind of occupation. Some women may turn to illegal activities to support themselves, including drug dealing and prostitution, which in turn may lead to drug addiction. A lack of voice or power in the society can lead disenfranchised women to seek out men with social power in their neighborhood, often drug dealers and pimps. Single mothers living in dangerous areas may connect with drug-using circles in order to protect themselves and their children. In addition, drug use allows a woman to change her own physical and mental state, temporarily affording her a feeling of power to control her situation.

Drug preference, sometimes referred to as the *drug-of-choice phenomenon,* is also influenced by sociocultural factors (Inaba et al., 1997; O'Connor & Berry, 1990; O'Connor, Berry, Morrison, & Brown, 1995). Different drugs are popular in different sectors of society at different times. For example, cocaine was popular with

middle-class White women in the late nineteenth and early twentieth centuries until it fell out of favor when it became illegal in 1914. Women in the 1950s who were trying to lose weight commonly became addicted to legally prescribed stimulants, and women who were trying to control anxiety often became addicted to sedative tranquilizers. Young women in the 1960s, trying to fit into a "hippie" social group and alternative lifestyle, commonly abused marijuana and psychedelics. In the individualistic 1970s and 1980s, women were more likely to abuse cocaine and alcohol. Recently cocaine, in the less expensive smokable form known as crack, has become a significant drug problem for disadvantaged African American women. Heroin use, while frowned upon by middle-class users in the 1980s, has gained in popularity in recent years and is increasingly seen in adolescents and upwardly mobile young women. Currently, middle-aged and older women are often afflicted with an iatrogenic opiate addiction, the result of physician-prescribed pain medication. Alcohol, the legal drug of our culture, remains the drug of choice for many women, although it too goes through periods in which it is more or less fashionable.

Although drug preference may vary according to the historical period and a woman's particular social group, the majority of women who are addicted suffer from feelings of shame and guilt as a result of the strong cultural bias against inebriated and drug-addicted women. Addicted women are regarded as failures as partners, mothers, and workers even when the addiction is iatrogenic or part of the culture (Gomberg, 1988; Straussner, 1997). However, societal responses to addiction in women tend to differ according to the woman's social class and drug preference. Poor women who suffer from addiction are often threatened with the loss of their children. In contrast, pregnant middle-class women addicted to cocaine or marijuana are often counseled with no threats of losing custody of their children (Marwick, 1998). In some states, disadvantaged pregnant women addicted to opiates are forced to take methadone or are threatened with the loss of their children. Calls for criminalization of addiction in pregnant women reflect a continuing societal bias against drug-addicted women. Despite advances in addiction medicine, many still perceive drug addiction as a manifestation of poor moral standards and a lack of will power.

Psychological Factors

A woman's psychological vulnerability is another factor critical to the development of addiction. Women who for psychological reasons are unable to pursue age-appropriate ambitions may find the effects and experience of daily drug use attractive, and may quickly develop the disease of addiction. Psychological vulnerability often stems from maladaptive beliefs that a woman develops in child-

hood, in relation to her parents, siblings, other caretakers, or members of her social group. Beliefs that lead to the inhibition of ambitions (such as the desire to have rewarding work, to have intimate relationships, to be successful and happy, to be a good mother) are sometimes called pathogenic beliefs, because they directly lead to psychological problems and psychopathology (O'Connor & Weiss, 1993; Weiss, Sampson, & the Mount Zion Psychotherapy Research Group, 1986; Weiss, 1993). According to Weiss's theory (often referred to as Control Mastery theory), many psychological problems are associated with pathogenic beliefs derived from aversive childhood experiences. These beliefs may warn a woman that if she pursues age-appropriate developmental goals, she will hurt someone she loves. For example, a woman who grows up with a depressed mother may believe it is her responsibility to ease her mother's pain—a task often doomed to failure. She grows up with the belief that she has harmed her mother, because she couldn't make her mother happy. She believes that to be happy and successful herself would be unfair to her mother. She may think, "I couldn't make my mother happy, so what right do I have to be happy?" As a result, she may be unable to develop a successful work or family life. Similarly, a child who grows up with a physically or cognitively disabled sibling may suffer from "survivor guilt" and believe that she doesn't have the right to be better off than her sister or brother. Thus she may hold herself back from success because she believes her success would make her sibling feel inadequate by comparison. Survivor guilt—that is, guilt derived from the belief that one is harming others by surpassing them, being better off, being successful or happy—is a normal psychological mechanism that, when exaggerated, is often connected to psychological problems, including addiction (Bush, 1989; Meehan et al., 1996; O'Connor & Weiss, 1993).

Women who grow up in drug-addicted families may develop the belief that to be loyal to their addicted mother, father, or sibling, they too must use drugs. Thus women from drug-using or otherwise dysfunctional families may begin using drugs out of an identification with and loyalty to their loved ones. They may believe that in order to avoid harming family members, they must inhibit their ambitions. They then become vulnerable to psychopathology, including depression and addiction.

In some cases, when a woman suffers from psychological problems derived from pathogenic beliefs or from a biologically based dysfunction such as bipolar illness or obsessive-compulsive disorder, she seeks and uses drugs regularly in an effort to overcome symptoms, such as guilt, shame, anxiety, depression, or an exaggerated sense of responsibility. In fact, most pathogenic beliefs, including the beliefs associated with addiction, lead to guilt, shame, anxiety, and depression. Despite the varying nature and effects of different drugs of abuse, most drugs function initially to reduce

guilt and shame and other negative affects. Over time, however, drugs that initially serve to alleviate these symptoms stop working and instead cause the symptoms to escalate.

Effects and Ramifications of Commonly Abused Drugs

This section discusses the use of and withdrawal from specific drugs of abuse. Addictive drug use over time mimics a variety of psychiatric disorders, and it is important to recognize that many symptoms may not be premorbid and should be reassessed after acute and protracted withdrawal has subsided (O'Connor et al., 1992, 1995). In the initial phases of treatment, the drug-addicted woman often creates a confusing clinical picture. It may take many months of abstinence from drugs before the clinician is able to determine how many of the patient's problems are neurochemical, temporary drug effects derived from use and how many are truly "psychological" in nature. The experience of drug abuse and addiction itself leads to massive social and psychological disruption (Bean, 1981). Many women who have been addicted have experienced painful and depressing losses in addition to the emotional, physical, and sexual trauma connected to their addiction. Many women have participated in the destruction of their physical and mental health, their relationships and families, and their jobs and means of livelihood. Women suffering from addiction are not gratified by their condition, and no addicted woman wants to be addicted.

All drug abuse will eventually cause both biologically and psychologically based guilt, shame, anxiety, and depression (O'Connor et al., 1992; O'Connor et al., 1994; Meehan et al., 1996). Women in the grip of drug addiction commonly present with these unpleasant feelings and may not know that the feelings are directly caused by the pharmacological and neurochemical effects of drug use and withdrawal. When first seeking help, addicted women may deny or minimize the extent of their drug use, and on the face of it they may appear to want to continue using. However, this denial is usually a manifestation of hopelessness (O'Connor & Weiss, 1993) and is, in essence, a defense against it. Women addicted to drugs most often try to stop using and fail. They interpret their failure as a sign of psychological weakness or moral deficiency rather than as the result of the disease of addiction. As a defense against this pessimistic perspective, they deny the extent of their addiction. Thus a drug-addicted woman may enter treatment denying the extent of her addiction, complaining instead of depression, worry, insomnia, and anxiety. Nevertheless eager to recover, however, the woman in denial will manage, often early in treatment, to coach the therapist to take note of her problem with substances (Bugas & Silberschatz, 2000).

Alcohol, Antianxiety, and Sedative Medications

Although alcohol and sedating medications are legal, they are often abused and may lead to dysfunctional behavior. In 1994, 2.6 percent of women reported heavy alcohol use (U.S. Department of Health and Human Services, 1997), and in 1998, 2.1 percent of women reported nonmedical use of prescription drugs (U.S. Department of Health and Human Services, 1998). Alcohol and sedating substances such as the benzodiazepines (Valium, Xanax, Ativan, Klonopin) initially cause a mixture of an anxiolytic and sedating effect, elevating mood and lowering anxiety and inhibitions. After a short while, sedation increases, accompanied by loss of muscle coordination and depression. Withdrawal from these drugs causes the opposite effect: excessive anxiety and fear, insomnia, restlessness, the "shakes," and potentially life-threatening seizures. Thus treatment providers will encounter a different clinical picture depending on whether the addicted woman is intoxicated or in withdrawal at the time of assessment. Although alcohol and antianxiety medications are legal and often considered less harmful than opiates or amphetamines, in fact the withdrawal from these substances is the most life threatening. A medically supervised withdrawal and detoxification from alcohol and sedative drugs is indicated. Often medications are prescribed to control seizure activity, anxiety, and insomnia.

Marijuana

Marijuana is a deceptive and pernicious drug, and its use is difficult to assess. Although marijuana was promoted in the late 1960s and 1970s as a benign and nonaddictive high, regular use of the drug has been shown to lead to physical dependence and a distinct withdrawal syndrome. Marijuana use often causes loss of ambition, interference in goal-directed behavior, and a degree of disorganization frequently called *amotivational syndrome.* A woman who has been regularly using marijuana is unlikely to be highly functional, although the degree of impairment may be less striking than that seen with other drugs. If the woman has used marijuana within the last few hours, her eyes may be red (although she may conceal this with eye drops), but otherwise there may be no obvious signs or symptoms. During the course of treatment, however, it will soon be evident that the woman is unable to achieve her full potential and is often mired in complicated relationships and family problems. For some women, marijuana use increases irritability except immediately after use. Marijuana, like other drugs, impedes development and leads to depression. In addition, as marijuana use progresses, it tends to induce feelings of anxiety and paranoia. It also affects a woman's hormone production, immune system, pulmonary function, and reproductive

system. (For a summary of specific effects on the body, see Doweiko, 1993; Inaba et al., 1997.)

Withdrawal from marijuana may be subtle and drawn out as a result of marijuana's long half-life in the body. It ordinarily sets in about three to six weeks after cessation of drug use and may include irritability, copious crying, a severe depression, anxiety, insomnia, excessive rumination, guilt, and shame. In addition, people have also reported physical symptoms, such as nausea or vomiting, lack of appetite, sweating, and a general flu-like condition (Haney, Ward, Comer, Foltin, & Fischman, 1999). Marijuana addiction is difficult to overcome. Despite its reputation as a "lighter" drug, the amotivational syndrome, depression, and accompanying drug craving may persist for over a year, diminishing slowly over time.

Stimulant Drugs

The stimulant drugs, cocaine and amphetamines, have a long history in the saga of women's addiction. Cocaine was an ingredient (along with heroin) in the "tonics" popular with women in the late 1800s and early 1900s (Fields, 1995; Inaba et al., 1997). In the 1950s and 1960s, amphetamines were frequently prescribed to women for weight control and the "housewife blues." Stimulants result in decreased appetite, wakefulness, agitation, feelings of euphoria, and, after prolonged use, paranoid ideation and psychotic symptoms such as auditory hallucinations. For a time in the 1960s and 1970s, cocaine was considered to be nonaddictive. This myth was quickly dispelled by animal experiments in which it was demonstrated that cocaine was the most reinforcing drug known: if given the opportunity, primates would self-inject cocaine, forgoing food and sleep, until they died.

Stimulants may decrease depression when first ingested. After the initial "high," however, the user quickly becomes depressed unless she uses more of the drug. Stimulant use is often accompanied by alcohol or other sedative abuse, as the user attempts to minimize the agitating effects of the drug. Stimulant abuse may mimic bipolar illness, the woman appearing to be in a manic state while using, and depressed when the high is subsiding. Withdrawal from cocaine and amphetamines causes anhedonia (inability to feel pleasure), and a woman in early recovery can be expected to suffer from anxiety, excessive sleep, and depression.

Opiate Drugs

Narcotic drugs or opiates also play a part in the history of women's addiction, as they too were included in the popular tonics of the late nineteenth and early twentieth centuries (Doweiko, 1993; Inaba et al., 1997). In recent years, opiate abuse

common to women has included illegal use of heroin as well as both legal (prescribed) and illegal use of pain medication such as codeine, Percodan, Vicodin, and other analgesic drugs. Opiates, similar to other "downers" such as alcohol and sedatives, initially decrease anxiety, decrease guilt and shame, and cause muscle relaxation and feelings of euphoria. In addition, opiate use causes constipation, cough suppression, pupil constriction, and hormonal and other physiological changes. Withdrawal from opiates may cause anxiety, restlessness, diarrhea, cramps, chills and flushes, intense craving, and depression. Although opiate withdrawal is often likened to a bad case of the flu and is highly unpleasant, it is not life threatening in most cases, unlike withdrawal from alcohol and sedatives.

Assessment

Pathways to addiction are highly individual and case specific, and case specificity is an underlying principle of assessment and treatment (Lieb & Young, 1994; O'Connor & Weiss, 1993). Because of the shame surrounding addiction, many women will not directly seek help for this problem, but instead will visit a therapist or physician with complaints of anxiety, depression, or insomnia (Straussner, 1997). The initial process of assessment is crucial to recovery (Brown, 1985): a misdiagnosed case may lead to years of further drug use; psychiatric problems; and loss of family, health, freedom, and life itself. For example, Susan was a young polydrug abuser who came to a low-fee clinic for psychotherapy, presenting with insomnia, anxiety, and depression. Her first two therapists, inexperienced psychology trainees, failed to ask about her drug history and current use, and diagnosed her with generalized anxiety disorder, depression, and borderline personality disorder. Even after Susan had attended several therapy sessions inebriated, the second therapist continued to focus on what she perceived as Susan's "underlying conflicts." The therapy was unsuccessful, and Susan endured two more years of escalating addiction and turmoil in her life. Susan's third therapist, who had prior experience with substance-abusing clients, focused the treatment on Susan's drug use and her desire to get into recovery. Within three months, Susan was abstinent and overcoming the many other problems that had been precipitated by her addiction. Susan, like many drug-addicted women, was highly motivated to recover and kept trying therapy until she found a therapist who was able to help her. Brown (1985) offers many examples of psychotherapists failing to identify alcohol or other drugs as their client's primary problem. In reporting on several studies of alcoholics recovering in Alcoholics Anonymous (AA), Brown (1985) notes this failure as "the primary [source] of hostility" (p. 4) between AA members and their therapists. In many cases, the window of opportunity for treatment may be short, and

it is in the treatment provider's hands to make an accurate assessment and case-specific treatment plan.

Many women seeking help for addiction, even when the addiction is initially disguised as some other emotional problem, will coach the therapist or physician by noting something related to drug use, either their own or someone else's (Bugas & Silberschatz, 2000; O'Connor & Weiss, 1993). They may mention drinking, or taking prescription drugs for anxiety, or using drugs with friends or their partner (Brown, 1985). In the absence of direct comments about drug use in the initial interview, the therapist should ask women about their use of drugs, including alcohol and prescription medications. Without knowledge of the client's drug use, a therapist is unable to properly diagnose a woman's presenting symptoms. Drugs affect brain chemistry, and a woman who appears to be clinically depressed or suffering from an anxiety disorder may in fact be suffering from addiction to alcohol, sedatives, marijuana, opiates, or stimulants. Women who do not come forward with information about drug use will most often be willing to answer direct questions, although they may minimize the extent of their drug involvement in fear of social disapproval or a demand that they stop using drugs before they feel able. Despite some women's initial reluctance, denial, or minimization, all addicts want to stop using drugs and want to overcome their problems (Brown, 1985; O'Connor & Weiss, 1993; Weiss et al., 1986).

In some cases a woman may appear "resistant" to treatment: she may minimize the extent of her drug use or continue to use despite obvious and concrete problems caused by her addiction. She may insist that drugs are not a problem and that her use is recreational. Or she may persistently suggest that her children, her parents, her marriage, or her job are the source of her difficulties. This "resistance" is ordinarily due to fear, guilt, and hopelessness. A woman may be terrified of drug withdrawal, particularly if she has tried repeatedly to withdraw from drugs and found herself unable to do so. In cases where the woman is from a family in which drinking or drug use is part of the family culture, she may fear losing her family (Brown, 1985; O'Connor & Weiss, 1993). She may suffer from survivor guilt toward family members: she may believe that if she gets off drugs, she will make her addicted mother or father feel bad by comparison. A woman with children may believe she will be abandoning her children should she need to enter a residential or hospital-based program due to the severity of her physical dependency. She may believe involvement in recovery will mean she is failing her partner and children. She may believe she is an inherently flawed person, unable to live without drugs. Many women believe they do not deserve recovery; in compliance with critical or disapproving parents, they believe it is their lot in life to be addicted and unsuccessful. Thus a major goal of early therapy is to systematically counter the beliefs that underlie or fuel the "resistance." Wanting re-

covery, a woman carefully and deliberately works with her therapist to try to change the maladaptive beliefs that are warning her against recovery (Brown, 1985; O'Connor & Weiss, 1993; Lieb & Young, 1994).

Treatment

There are many varieties of treatment for drug-addicted women, and the selection of a particular kind of treatment is based on a woman's particular needs and situation, her unique psychology and chemistry, and the severity of her addiction. In many cases, a medical detoxification is required, particularly when there are sedatives, alcohol, or tranquilizers involved. Sometimes a period of hospitalization is needed. In some cases, when a woman is living alone, isolated, or without social support, treatment that follows a residential social model is recommended. In many cases, self-help programs like AA, Narcotics Anonymous (NA), or other drug-specific programs modeled on AA (Cocaine Anonymous, Marijuana Anonymous, Nicotine Anonymous) are the primary mode of treatment, sometimes used alone and sometimes in conjunction with psychotherapy. Other self-help groups, such as Rational Recovery (RR) and Secular Organization for Sobriety (SOS) are helpful in cases where any reference to religious language is intolerable. Women-centered groups such as Women for Sobriety (WFS) and women-only AA meetings may be extremely useful for women.

In some cases, pharmaceutical intervention in early recovery includes the use of medications that are presumed to make drug use either unattractive or less desired. For example, Antabuse works to make an alcohol-addicted person sick if she drinks. Naltrexone, which counteracts the effects of opiates, is sometimes used in conjunction with psychosocial treatment of opiate addiction and is currently also being used in alcohol addiction, as it appears to reduce the craving for alcohol.

Methadone, a synthetic long-acting opiate, is often used to detoxify from heroin, although its use is controversial. Advocates of methadone detoxification report the following benefits: it is effective in reducing the craving for heroin; it prevents the addict from achieving a heroin "high" should she use; it removes the addict from illegal drug-related activity; and it does not require injection (it is administered once daily in liquid form), thus lowering the risk for transmission of HIV and Hepatitis C. Furthermore, methadone detoxification brings the addicted woman into daily contact with the treatment program, as she is required to come every day to get her methadone dose. Proponents of methadone claim that addicts who participate in a methadone program don't continue to use heroin and other drugs. Methadone advocates also suggest that methadone allows for an easier detoxification from heroin. However, many heroin addicts who begin

methadone in a detoxification program end up staying on methadone indefinitely. Treatment providers justify this with the argument that opiate addicts suffer a chronic deficiency in the endorphin system in the brain and therefore need methadone maintenance to compensate for this deficiency (Dole, 1988).

Critics of methadone detoxification object to this perspective, believing that opiate addicts are capable of full and abstinent recovery. They point to studies demonstrating that addicts on methadone continue to use other drugs, such as cocaine, alcohol, and heroin at the same time as using methadone (see Wasserman, Korcha, Havassy, & Hall, 1999). They further support their critique by referring to the many abstinent recovering heroin and methadone addicts who have reported they were able to get high on heroin while using methadone (Inaba et al., 1997). In addition, withdrawal from methadone is far more long lasting, painful, and severe than heroin withdrawal. Furthermore, recovering heroin addicts report that the experience of methadone addiction is humiliating, and it keeps them from participating in an abstinence-model recovery program such as Narcotics Anonymous. Methadone maintenance, usually started in an effort to withdraw from heroin, has been called a "chemical prison" by recovering opiate addicts.

Other medications sometimes used in early recovery include antianxiety drugs, although most treatment specialists believe there is too high a risk of dependence, and limit antianxiety medications to a few days. Sedating antidepressants are sometimes used to help a woman sleep while undergoing withdrawal. Antiseizure medications may be necessary for women withdrawing from alcohol, sedatives, or tranquilizers. Clonidine, a blood pressure medication, has been found effective in countering some of the effects of opiate and nicotine withdrawal. Antidepressants may be used to reduce the depression and anxiety frequently associated with withdrawal.

The use of medications by substance-abusing women is controversial in some recovery circles. The abstinence model of recovery (refraining from all mind-altering drug use), has been effective for many addicts, and to some, any drug affecting the brain is considered dangerous to one's sobriety. Complete abstinence is often a particularly successful model of treatment for a variety of reasons. Addiction is often referred to as a chronic and relapsing brain disorder, and the abstinence model appears to provide protection against relapse (Margolis & Zweben, 1998; Rawson, 1994). In many cases, people who believe they only need to stop using their drug of choice find that continuing their use of other drugs leads them back to their preferred drug or that they become dependent on a new drug. For example, a woman who had successfully overcome her addiction to heroin in a residential drug treatment program developed a serious addiction to alcohol when she resumed drinking. She thought she could drink because, she said, "Alcohol was never my problem." Many drugs of abuse have the effect of lowering inhibitions,

and when drug-dependent women are uninhibited they are more likely to resume use of their preferred drug. The abstinence model also avoids the effects of state-dependent learning: when using any substances, women are more likely to remember the drug euphoria they first experienced when they began using drugs and to suffer from drug craving. Abstinence is further justified by the escalating nature of the disease of addiction: studies of addiction in rats show that with repeated administration of an addictive drug there is an increased reward threshold, meaning that it takes more of the drug to have a rewarding effect (Koob & LeMoal, 1997). Other studies have demonstrated that when rats are addicted to alcohol, then withdrawn and subsequently addicted again, each successive withdrawal syndrome is more severe. This is known as the *kindling effect* (Becker, 1998; Maier & Pohorecky, 1989). These study results are in accordance with an AA principle: addiction escalates in severity, and each time a woman relapses, her illness becomes more severe.

A currently popular, though controversial, treatment approach is known as *harm reduction*. This treatment modality acknowledges that many addicts are unable to achieve abstinence and that making a drug-free life a goal of treatment leads to disappointment and a sense of failure. Instead, advocates recommend that the goal of treatment be a reduction in drug use. Although harm reduction may be an effective model for some women in recovery, for many women it is a high-risk strategy. For example, Audrey Kishline, a leader in the controlled drinking model of treatment, killed two people in an automobile collision as the result of driving with a blood alcohol level of .26. Facing arrest, Kishline stated that Moderation Management is a "program for alcoholics covering up their own alcoholism" (Rivera, 2000, p. 47). Dr. Ernest Nobel, director of UCLA's Alcohol Research Center, notes that "attempts at moderation, such as Controlled Drinking, Drink Watchers, and Rational Recovery, have a long history of failure" (Rivera, 2000, p. 47).

Social Model Programs

In treatment following the social model programs, recovering addicts live and work together, usually under the supervision of longer-term recovering addicts. In some social model programs such as Delancey Street Foundation in San Francisco, recovering people work in the program. In other programs, residents find employment in the broader community while living at the program facility. Social model programs emphasize the development of social skills, vocational skills, and a sense of personal responsibility—including taking responsibility for one's addiction and recovery. Based on programs initially designed for drug-addicted men, some social model programs tend to put great emphasis on taking responsibility, which

can be overinterpreted by women, creating an additional burden of guilt and shame. This may be counterproductive for drug-addicted women, who tend to blame themselves for everything prior to and during their addiction (Meehan et al., 1996; O'Connor & Weiss, 1993) and whose self-loathing and self-criticism are relapse triggers. Some social model programs, in the wake of increasing numbers of women seeking treatment, have revised their program design to be more appropriate for women. Such programs try directly to reduce women's feelings of exaggerated shame and guilt. Many women who otherwise might not be able to afford treatment (other than in self-help programs) find support, access to resources, psychoeducation, and a protected drug-free environment in social model programs. In addition, social model programs often are able to meet the relational needs of recovering women. For the increasing numbers of women arrested for drug-related crimes, social model programs may provide a more viable, more effective, and less expensive solution than imprisonment. Furthermore, drug treatment is more likely to prevent recidivism. The use of social model programs instead of prison may be especially relevant to minority women, who are being incarcerated at a much higher rate than European American women (Henderson, 1998).

Individual and Group Psychotherapy

Group or individual psychotherapy (or both) is often a necessary component of the addicted woman's treatment plan. In some cases, women are unable to stop using drugs until they have been in intensive psychotherapy long enough to disconfirm the pathogenic beliefs warning them against abstinence and recovery. For example, a woman may need to address the belief that if she pursues a successful life without drugs she will be betraying, deserting, or sneering at her alcoholic or drug-addicted parent(s) or sibling(s). Or a woman may need to address the inhibiting belief that if she stops using drugs she will be defying a parental dictate that she is supposed to be inadequate and out of control.

Clients deliberately—though often unconsciously—test their therapists. Consequently, a woman may need to test the therapist many times before sticking with AA and getting sober. In an effort to change the inhibiting beliefs derived from traumatic childhood experiences, clients take specific actions so as to find out how the therapist will react (O'Connor & Weiss, 1993; Silberschatz & Curtis, 1993; Weiss, 1993; Weiss et al., 1986). For example, a woman who believes she will harm her actively alcoholic mother by getting sober (perhaps she fears she will make her mother feel inadequate or inferior by comparison) will test this belief with her therapist. She may do this by saying she doesn't want to stop drinking, by saying she hates AA and that she doesn't have a problem or that the people at meetings are "much sicker than I am." Or the client may appear at a therapy session after drinking to

see if the therapist will notice, care, or feel hopeless about her. These activities are carefully designed tests of the therapist to see if the therapist supports the woman's abstinence and recovery. When the therapist consistently responds with a calm support for recovery, and treats her client optimistically, the client will be able to change the beliefs that prevent her from getting into recovery.

A therapist's countertransference, or internal emotional reaction to a client, helps the therapist understand the client's feelings. In general, it is likely that a patient is testing if the therapist experiences a strong emotional response to her or feels a strong pull to make an intervention. Therapists are able to understand the specific nature of their clients' tests by carefully noting exactly what they feel pulled to do or what emotion they are experiencing. For example, a client may test by treating the therapist as an authority figure or as a parent. In this scenario, the client has transferred her experience with her parents onto the therapist in order to test the pathogenic beliefs she developed as a child in relation to her parents. The client is acting with her therapist the way she did with her parents in the hope of attaining an experience different from the one she had as a child. For example, a woman who grew up with highly critical or neglecting parents—parents who perhaps were unable to acknowledge her achievements—may have the expectation that all authorities will treat her as she was treated by her parents and that she deserves their poor treatment. She may test this belief in relation to her therapist by describing a recent success of hers. The therapist, by responding to the client in a different way than her parents responded to her, may be able to help the client change some of her maladaptive beliefs, such as that she deserves to be criticized or neglected.

At other times, therapists will find themselves feeling guilty, inadequate, hopeless, or fearful in reaction to the client. In these instances, clients are most often actively imitating behaviors that they had to endure passively as children. For example, another client who was also unfairly criticized as a child may test her therapist by becoming harshly critical of her (playing the role of the parent instead of the child). Her therapist, in response, may find herself feeling like a "bad child" who can't do anything right. In this case, there may be several purposes to the client's test. One purpose is to unconsciously demonstrate what she had to endure as a child. This is particularly likely to occur if the client feels too guilty to verbally describe her parents' behavior or if she is not able to remember their behavior. Another purpose is to learn how to respond to criticism without believing that she is deserving of it. (By adulthood, the client has often internalized her parent's criticisms and, as a result, is constantly criticizing herself, usually in the tone her parents used with her when she was a child.) In order to provide a corrective experience and to pass the client's test in this situation, the therapist needs to accept or tolerate the client's behavior and understand it as information about the client's childhood. In addition,

the therapist needs to model a different response to the experience of being criticized. The therapist needs to let herself experience the test, to endure feeling like "a bad child" without actually believing that she is bad and deserves criticism. The client will then be able to imitate the therapist's response to criticism when she herself is faced with her internal parental criticisms.

Developing skill at noting and interpreting countertransference reactions is particularly important in working with women addicted to AOD. Many women with chemical dependency problems come from AOD-dependent families and have therefore experienced significant childhood trauma. While in treatment, they will need to test the beliefs they developed in their dysfunctional families, and the therapist must rely on his or her countertransference reactions in order to help the client.

Psychoeducation

The period of withdrawal from drugs is often very difficult and filled with physiologically based anxiety, depression, restlessness, insomnia or hypersomnia, fear, guilt, and sometimes hallucinations and psychosis. Understanding this process from a biopsychosocial perspective is most helpful. Most women in early recovery—whether they are in individual or group therapy, in a residential, inpatient, or outpatient treatment program, in AA, or in some combination of programs—are well served by obtaining education about addiction, through films, lectures, literature, and group discussions. Becoming an expert on their own addiction helps empower women to understand that even though they may be powerless over their disease, they are not helpless. The individual or group psychotherapist working with clients in early recovery can help by recommending educational materials, books, and videos and by being knowledgeable enough themselves to engage in in-depth discussions about addiction as a biopsychosocial disease. By learning about the biomedical and hereditary basis of addiction, the client builds a rationale—beyond an unquestioning belief in the treatment provider or program—for stopping drug use. Understanding protracted withdrawal—that is, the recurrence of withdrawal symptoms and accompanying craving long after abstinence—helps demystify the experience. For example, when a woman in recovery from alcohol addiction experiences a wave of severe anxiety and shaking, perhaps triggered by a drug cue such as a smell or sight, she may find herself thinking that she is a hopeless case and so may as well drink. However, if she understands the protracted withdrawal phenomenon and knows the reaction will pass, she is far less likely to relapse. Education about addiction and about the case-specific vulnerabilities of a client is a helpful weapon in the fight against relapse. Addiction is a relapsing disease, and many addicted women find themselves using again. Education about the facts of addiction is helpful in get-

ting a woman back into recovery. Countering the perspective that addiction is a moral weakness or a sign that the client is psychologically flawed and hopeless, the biopsychosocial viewpoint is far more accurate and helpful.

The Twelve-Step Model of Recovery

Over the past fifty years, AA (and, more recently, NA, Marijuana Anonymous, Cocaine Anonymous, and other twelve-step programs) has been a central part of many women's recovery, despite some male-derived aspects of the program. Twelve-step programs, like other self-help groups and group therapy, are often helpful because they give women the opportunity to hear about the experiences of other recovering women (Brown, 1985; Lieb & Young, 1994; O'Connor & Weiss, 1993). This breaks their sense of isolation and uniqueness and validates and normalizes their experience. Women in AA and NA are particularly helped by hearing women's stories in speaker meetings and in women-only meetings. Although twelve-step programs do not work for everyone, they work for many. Women who are not successful with the program alone may find that it works when combined with other treatment, such as residential treatment, transitional halfway houses, hospital inpatient or outpatient programs, group or individual psychotherapy (or both), and, in some cases, medical detoxification or psychiatric medications.

AA and NA, like other helpful treatments, help counter women's pervasive sense of shame and guilt and their exaggerated sense of responsibility for others. The often-criticized "spiritual" component to the twelve-step program is particularly effective in this process. The first step of the program, sometimes considered controversial by feminist women, suggests accepting that "We are powerless over drugs and alcohol and our lives have become unmanageable." Objections to this step relate to the declaration of powerlessness, with the assertion that women already feel too powerless and that in order to recover they need to feel powerful. In fact many, if not most, drug-addicted women suffer from an exaggerated sense of power, the persistent fear that they are harming others, and the belief that if they are successful and sober they will harm a loved one. The first step helps counter this belief in their omnipotence. The second and third steps, calling on a belief in a "power greater than ourselves," also help women put into perspective their omnipotent sense of responsibility for others. These steps ask the addicted person to put control into the hands of a "Higher Power." A Higher Power may be viewed as God or Buddha or some other spiritual entity, or it may be a belief in nature or the twelve-step group or some other entity of the woman's choosing. Belief in a Higher Power offers guilt-ridden women a more realistic sense of their power over others for whom they feel an omnipotent sense of responsibility.

Some women are unable to make use of AA or NA until they have been in psychotherapy for a while, and others are never able to connect to a twelve-step program. Twelve-step and other self-help programs may be less immediately useful for some women with particular kinds of problems, such as intense shyness, severe psychopathology, or employment in a public position in which it would be detrimental to their work to appear in a public treatment setting. Some professionals have formed professional AA and NA groups to work around this problem. There are AA and NA groups for doctors, lawyers, and mental health professionals in many communities. Women who have recently immigrated from another country, or women who are contending with physical disabilities and illness, may also find themselves unable to make good use of twelve-steps programs. Women who are from a culture in which it is considered highly inappropriate to discuss personal issues in public may likewise find it difficult to make use of these programs. Case-specific treatment planning is essential in designing the optimal program for any woman. Often, when a woman finds that AA or NA is authentically not helpful, the therapist or counselor should try to find other resources in the community that will better suit her client's particular situation.

Additional Issues Affecting Treatment

As mentioned earlier, it is difficult to diagnose other mental disorders until a woman has a period of time abstinent from drugs; the length of time needed to make that assessment varies. Most women in early recovery will have at least some symptoms of a mood or anxiety disorder, and to treat these symptoms as indicators of a non-drug-related depression or anxiety disorder is controversial (O'Connor et al., 1992).

Historically, many clinicians, influenced by a traditional psychodynamic perspective on addiction, have assumed that drug-addicted women are suffering from a personality disorder, a mood disorder, or some other underlying psychiatric problem or manifestation of unconscious conflict. This perspective resulted in clinicians' denying or minimizing the importance of drug use and led to treatment failures. Many chemical dependency specialists concluded that psychotherapy was harmful to drug-addicted women.

As a result of this history, some HMOs currently deny psychotherapy to drug- and alcohol-abusing women. This is problematic for women who need therapy in order to overcome inhibitions against recovery and for women who are suffering from mental disorders independent of their drug use. There are women in recovery who have been using drugs to control the symptoms of severe psychiatric illnesses. This includes problems such as the mania and depression of bipolar illness; the ruminations, anhedonia, and sleep disturbance of major depression; the ob-

sessions and compulsions of obsessive-compulsive disorder; and the self-destructive behaviors of a severe personality disorder. The dually diagnosed woman requires a comprehensive treatment plan that includes a highly supported withdrawal and early recovery period, early or continuous trials and use of medications, and ongoing psychotherapy. Women suffering from psychotic or other illnesses that result in unusual social behaviors may have a hard time fitting into AA or social model programs until they have their more overt symptoms under control.

Conclusion

The need to provide AOD-dependent women with appropriate gender-sensitive assessment and treatment remains a significant issue for the mental health system as a whole and for psychotherapists working with this population, be they in HMOs, community mental health settings, or private practice. Drug and alcohol dependence causes many of the mental health problems affecting our society and has a widely felt destructive impact. Not only are AOD-addicted women themselves suffering, but so are their families and their social and work groups. The cost of drug and alcohol addiction spreads exponentially as it ripples throughout whole communities. However, treatment for even one drug-dependent woman has the potential to save numerous lives. There are many kinds of treatment for addiction; the urgent issue is to make treatment more accessible and sensitive to the particular needs of women, and to educate psychotherapists working with AOD-addicted women and their families.

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