Recognizing gender differences: A comparative analysis of two substance abuse treatment programs

Judyth Lynne Scott
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RECOGNIZING GENDER DIFFERENCES: A COMPARATIVE ANALYSIS
OF TWO SUBSTANCE ABUSE TREATMENT PROGRAMS

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirement for the Degree
Master of Social Work

by
Judyth Lynne Scott and Linda Diane Pettine

June 1997
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ABSTRACT

This study explored the treatment of women's substance abuse from a critical theory perspective. The literature indicates that, within substance abuse treatment programs and in the research world, few treatment programs are sensitive to women's specific needs. The researchers conducted a comparative analysis between a program providing gender-sensitive components, and a program "traditional" in orientation. The impact of the inclusion of gender sensitive components on women’s completion and sustained recovery was assessed. Qualitative and quantitative methods of data gathering and analysis were utilized. Quantitative results indicated that there were no significant differences in completion rates between programs. However, qualitative responses concur with the literature, indicating that gender sensitive components such as child care, women’s support groups, and individualized counseling support women’s program completion and continued abstinence. The goal of this study was to further explore women’s treatment program needs, and facilitate the development of programs that empower women and support their substance abuse recovery.
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INTRODUCTION

Within the field of addiction, the centrality of patriarchy has meant that the situations and needs of women were largely unacknowledged within both substance abuse treatment and the research world (Ettorre, 1989). It was not until the mid 70s that increased attention was directed specifically to women as a separate category of substance user (Abbott, 1994).

The failure to adequately diagnose and record addiction in women, their secretive patterns of drinking and drug use, and a long tradition of limited research on female populations has resulted in a lack of scientific information about the number of women who abuse various substances, and their involvement in treatment (Naegle, 1988). Furthermore, few treatment programs are sensitive to women's specific service needs, such as nutrition, child care, parenting skills and knowledge, medical/reproductive issues, and counseling for incest and domestic violence experiences (Eliason, Skinstad, & Gerken, 1995).

This research examines women's substance abuse with an aim toward 1) determining what components can be added to treatment programs to better meet the needs of women substance abusers; 2) determining what differences may exist in program completion rates between female clients in
programs meeting women's needs, and those without supportive components; and 3) edifying social work practice such that we facilitate, through consultation and/or program implementation, inclusion of treatment components compatible with women's specific treatment needs.

Problem Statement

Recent reports estimate that the direct and indirect costs of alcohol and drug abuse in this country approach $115 billion (Sullivan, Wolk & Hartmann, 1992). Although nearly one-fourth of these costs can be attributed to treatment services, 37% of the total outlay is from lost or reduced productivity (morbidity) among the afflicted. Significantly, 96% of the morbidity costs associated with alcohol- and drug-related problems are associated with clients outside institutional care (Sullivan et al, 1992). Mortality among women diagnosed as alcoholic is high, both when compared to the general population of women and to rates of excess mortality in alcoholic men (Blume, 1990).

Drug abuse and dependence in selected U.S. populations affect 5-6% of individuals at some time of their lives, and 11-16% experience drug abuse and/or dependence on alcohol (Naegle, 1988). According to recent estimates published by the Alcohol, Drug abuse, and Mental Health Administration (Lehman, 1991), about 5 percent of American women abuse or
depend on nonalcoholic illicit psychoactive drugs. Women average about one-third the population in each group, and women substance abusers come from all races and socioeconomic classes (Goldberg, 1995).

Differential drug use and dependency patterns have been noted in relation to ethnic and socioeconomic groupings. Heavy drinking has been found to be more common among Caucasian women than African American or Hispanic women. However, American Indian women have a significantly higher prevalence of drinking problems. Higher proportions of women within the lower socioeconomic classes have been correlated to heavy drinking (Goldberg, 1995). A socioeconomic analysis of women has shown that those who have substance abuse problems are often unemployed (Yaffe, Jenson, & Howard, 1995).

Heavy drinking (more than 2 ½ drinks per day) occurs in only about 5% of women drinkers (Goldberg, 1995; Naegle, 1988). An estimated 4.5 million women meet the DSM III criteria for alcohol abuse or dependence (McCollum & Trepper, 1995). According to the Statistical Record of Women Worldwide (1991), of the estimated 14 million alcoholics and problem drinkers in the United States, from 3.5 million to six million are women. The average duration of problem drinking before the first recorded incidence of
fatty liver disease, hypertension, obesity, anemia, malnutrition and gastrointestinal hemorrhage is 14.2 years for women, compared to 20.2 for men. In a follow-up of 103 women treated for alcohol abuse after 11 years, 31% of the women were dead.

Drinking is highly prevalent in the Northeast and the use of illicit drugs other than marijuana is common in the West (Naegle, 1988). Women under 40 describe drug-using histories more varied in experimentation and regular use than their older counterparts, who abuse and depend on alcohol more commonly.

A larger number of women than men, about 1.5 percent (Goldberg, 1995), abuse licit drugs such as tranquilizers, sedatives, psychoactive drugs, hypnotics, and stimulants (Lisansky Gomberg, 1982). Almost two-thirds of the prescriptions for psychotropic drugs are received by women (Abbott, 1994; Doshan & Bursch, 1982). Women far exceed men in their medical and nonmedical use of prescription drugs and are more likely to obtain these drugs from "legitimate" sources, including physicians (Nelson-Zlupko, Kaufman & Morrison Dore, 1995). Young adult women report a slightly higher prevalence of cocaine and amphetamine use as compared to men (Naegle, 1988).
Problem Focus

This research explored women's substance abuse from a critical theory perspective. Critical theory advocates use of research to bring about social change, and incorporates theories such as neo-Marxism, materialism, feminism and Freireism (Guba, 1990). These multi-theories reject the notion of value freedom research and focus on the ideologies that create injustice and deprivation for one group, while maintaining power and privilege for another. Critical theory examines these ideologies in a historical and present-day context (Guba, 1990).

Historically, the pervasive impact of patriarchy lies at the core of women's oppression. Murray (1995) states that patriarchy involves the economic, political, and ideological domination of women by men, which may include but is not limited to sexual domination and male power.

Patriarchy developed between the fifth and second millennium B.C. when men became aware of the relationship between coitus and childbirth, and ceased to hold women sacred (Day, 1989). Men began to assume power and develop religions that legitimated that power (Day, 1989; French, 1992).

One of the major values that emerged out of this patriarchal ideology was the Protestant work ethic, which
asserts that poverty is a result of personal inferiority and that aggressive pursuit of wealth is a characteristic of superior human beings (French, 1992). Since the largest majority of the poor have historically been women and children (Day, 1989; French, 1992), this ideology becomes an indictment on women as a class.

The development of social policy is a political process (Day, 1989). Throughout history, women have had the least access to power or political experience because women are largely excluded from this arena by men (French, 1992). This leaves women with no voice in political decision-making, and allows the continued development of policies that hurt women.

In the economic arena, women's lack of power has meant that while they have done between two-thirds and three-fourths of the work in the world, and produced 45 percent of the world's food, they are still granted only 10 percent of the world's income and 1 percent of the world's property (French, 1992). Women have historically received less pay for equal work, even after the passage in the 1940's, of equal pay for equal work legislation (Day, 1989).

The judicial system and its laws have historically disenfranchised women. Laws have legitimated the dominance of women by men. In colonial times, women had no property
rights and no legal recourse (Day, 1989). Up through the 1800's, women could not vote, sign wills or contracts without their husband's consent, or serve on juries (Day, 1989). The prostitute was punished and arrested more often than the consumer of her services (Day, 1989), a practice which continues today.

In the field of education, patriarchal ideology discouraged women's participation. During colonial times, girls education typically took place at home, where they learned to perform household tasks and, occasionally, to read. At the end of the colonial era, less than half of the women in New England could sign their names, and female literacy elsewhere was even lower (Foner & Garraty, 1991). Women were denied access to higher education, and were not afforded equal educational rights and the right to write, speak and teach on a basis equal to men until the 1800s (Day, 1989).

The professionalization and "ownership" of medicine by men led to the suppression of midwifery as a legitimate medical practice (French, 1992). Once men dominated the healing profession, they treated women differently from men 1) in diagnosis, which attributed many of their illnesses to gender-based causes; 2) by dismissing women's physical complaints as neuroses; and 3) by conducting medical
research that focused on men and was generalized to women (French, 1992), a practice still occurring today. Men generally controlled the medical field during the decade of the 1800s. Even after women's inclusion in the educational process they were largely excluded from medical practice (Day, 1989).

Thus we see that the historical oppression of patriarchy has permeated religion, politics, economics, justice, medicine, and education, every major institution of our society. Furthermore, the overarcing nature of one institution upon another makes the negative impact of patriarchy upon women that much greater (French, 1992).

Today, irrespective of race, socioeconomic class, and educational background, women are still denied access to positions of power, status, and economic security more often than men (Gomberg, Nelson & Hatchett, 1991; Nelson-Zlupko et al, 1995). Women who work outside the home still face discriminatory hiring and wage practices (Goldberg, 1995), and women who participate in the paid work force are less likely than men to hold positions of power. In the United States, women experience much higher rates of poverty than men, and female-headed households constitute the largest percentage of impoverished families (Finkelstein, 1994; French, 1992; Nelson-Zlupko et al 1995).
Due to gender differences in salaries and benefits, women who work frequently lack adequate medical coverage or medical leave time to enter traditional programs (Abbott, 1994). Financial destitution and the resultant dependence on men, family members, or the welfare system keeps women in a powerless role (Zankowski, 1987). Furthermore, women who seek treatment soon discover that treatment programs are largely male-oriented (Abbott, 1994; Nelson-Zlupko et al, 1995; Gustavsson & Rycraft, 1994). Substance abusing women are more likely to identify with traditional sex roles, yet they have failed in making these roles work for them (Zankowski, 1987). Women in recovery require a great deal of support and freedom from the dictates of the female role. The related social and psychological pressures make it difficult for them to assume adequate responsibility for themselves in order to make therapeutic progress (Bepko, 1989). In some treatment programs, 60 to 70 percent of women clients have children and many have the primary or sole responsibility for child care (Yaffe et al, 1995).

**LITERATURE REVIEW**

The power relations that undermine women's opportunities, disenfranchise women as a group, and ultimately promote oppression contribute to women's substance abuse. This abuse can be linked to women's
socialization and resulting assessments about themselves as powerless and inadequate (Naegle, 1988), accompanied by feelings of hopelessness, helplessness and despair (Abbott, 1994). Bepko (1989) asserts that for women, a paradoxical relationship exists between a desire for power through drug use and a resulting disempowerment. Therefore, social oppression of women becomes internalized through drug dependence and self oppression. However, several factors related to oppression appear to have a special association with the lack of retention, completion rates, and sustained recovery for women in treatment.

Women's failure rates in traditional drug treatment programs are not surprising given that such programs have been designed primarily by men for male clients (Abbott, 1994; Goldberg, 1995) and thus do not meet the needs of women (Finkelstein, 1994; Nelson-Zlupko et al, 1995). The traditional model for substance abuse treatment was initially developed for homeless and unmarried men (Kaufman, Dore & Nelson-Zlupko, 1995). Furthermore, their approaches have been informed by research conducted on male substance-abusing populations (Abbott, 1994; Doshan & Bursch, 1982; Kauffman, Dore & Nelson-Zlupko, 1995; Nelson-Zlupko et al, 1995).
The few studies which examine treatment effectiveness rates for women abusers generally indicate less successful outcomes for women than for men (Doshan & Bursch, 1982; Ettorre, 1989; Nelson-Zlupko et al, 1995). Rates of entry into treatment, retention, and completion of treatment are significantly lower for female clients than for male clients (Mammo & Weinbaum, 1991; Nelson-Zlupko et al, 1995). Blume (1990) says that while this is partly a result of social stigma, it is also a result of casefinding systems that concentrate on convicted drinking drivers, public inebriates, and workplace intervention programs, all of which are more effective in reaching male alcoholics. Women are seriously underrepresented, particularly in alcoholism treatment (Blume, 1990). National surveys show a ratio of males to females of 2 to 1 among adults with significant alcohol problems, while the ratio of males to females in treatment in 1987 was 4 or 5 to 1.

Sex role differentiation plays a dominant role not only in women's drug use but also in women's unwillingness to seek treatment for substance abuse (Abbott, 1994; Gomberg, Nelson & Hatchett, 1991; Nelson-Zlupko et al, 1995). Women tend to carry primary responsibility for child care and the care of others in their families (and many are) discouraged from participating in treatment by a family member who
perceives the addict's involvement in treatment as a threat to her ability to care for the family (Nelson-Zlupko et al, 1995).

On-site child care services are essential for retention and recruitment of women into treatment (Kauffman, Dore & Nelson-Zlupko, 1995). Very few drug treatment programs offer on-site child care or provide help in making child care arrangements (Nelson-Zlupko et al, 1995). Mothers receiving public assistance may lose their income if they go into treatment and have the children with someone else (Goldberg, 1995).

Substance-abusing mothers also need family support services which provide parenting skills (Olsen, 1995; Plasse, 1995; VanBremen & Chasnoff, 1994; Yaffe, Jensen & Howard, 1995; Zankowski, 1987) family counseling, intensive family preservation, medical care, prenatal care, child development and nutritional needs, transportation, and advocacy for public assistance, housing, food and other survival essentials. (Copeland, Hall & Didcott, 1993; Finkelstein, 1994; Reed, 1987; Yaffe et al, 1995; ). Family counseling is vital because women are often involved with substance abusing spouses or partners who are resistant to treatment, fail to understand the impact of drug abuse on the family, and present barriers to their recovery.
The need for sensitive, caring, nonjudgmental, nonconfrontational, and empathetic staff members is crucial to engaging women in substance abuse treatment. Trusting therapeutic relationships with therapists and staff members are needed to address painful issues and avoid relapse. These issues include: sexual abuse, incest, physical abuse, rape, battering, guilt, shame, child abuse, depression, and low self esteem (Barber, 1995; Beckman & Amaro, 1986; Boyd, 1993; Carten, 1996; Clayson, Berkowitz & Brindis, 1995; Copeland, 1993; Finkelstein, 1994; Gomberg, 1988; Kaufman, Dore & Nelson-Zlupko, 1995; Nelson-Zlupko et al, 1995; Reed, 1987; Singer et al, 1995; Saunders, 1994; Saunders, Baily, Phillips et al, 1993; Wallen, 1992; Zankowski, 1988).

Nelson-Zlupko et al (1995) note that drug treatment participants are often encouraged to engage in cathartic sessions in which secrets are divulged. Although this can be experienced as a cleansing activity for some, for a sexually or physically abused woman, the experience of being pressured into public confession often leaves her feeling reviolated.

Women need to see female staff members in positions of power and leadership within the treatment setting to acquire positive role models (Nelson-Zlupko et al, 1995; Reed, 1987). Kauffman et al (1995) found that women only therapy
groups provided enhanced empowerment, sobriety, personal development, and independence. Women's experiences of self empowerment within treatment can be extended to other arenas of everyday living (Guiterrez, 1990). Women only groups and female therapists are integral to levels of self expression, supportive mutual aid, and comfort (Copeland et al., 1993; McCollum & Trepper, 1995; Reed, 1987; Wilke, 1994).

Mental health care and individualized treatment for affective and other psychiatric disorders are critical for drug addicted women, as many have a dual diagnosis (Boyd, 1993; Reed, 1987; Yaffe et al., 1995; Zankowski, 1987). Further, it has been found that pregnant women who were drug addicted had high rates of psychiatric disorders (Boyd, 1993; VanBremen & Chasnoff, 1994). In a study reported by Abbott (1994), the diagnoses of depression was much higher among female substance abusers (17%) than among alcohol dependent males (5%) or the general female population (7%). Furthermore, the author states that major depression is the most common additional diagnosis to accompany psychoactive substance use disorders in women.

Program components should include psychoeducational aspects that address how gender role and socialization issues affect women. Psychoeducation will provide alternative behaviors and foster higher levels of personal
control within their lives (Bepko, 1989; Gomberg, 1988; Zankowski, 1987). Chemically dependent women are more likely than men to use drugs in isolation and in private rather than in public places (Nelson-Zlupko et al, 1995). Social activities within the treatment and community settings help to increase social networks that support recovery (Reed, 1987; Wilke, 1994).

Aftercare programs for women promote social support and continue education in life management skills to substance abuse recovery. The skills of decision making, money management, vocational planning, assertiveness, parenting, and ability to use community resources help to buffer women from feelings of helplessness (Finkelstein, 1994; Reed, 1987; Yaffe et al, 1995; Zankowski, 1988).

Thus it becomes clear that the inclusion of gender sensitive treatment components can positively impact women's treatment experiences. Gender sensitive relapse prevention models which emphasize empowerment have been heavily sustained in the literature (Copeland et al, 1993). While studies have speculated about why women have lower treatment program completion rates than men, there has been little empirical research assessing the impact of inclusion of gender sensitive components in treatment. Researchers hope to 1) show, through a comparative analysis of treatment
programs, a correlation between gender sensitive treatment components, and a higher level of women's program completion, and 2) uncover and delineate women's treatment program needs to facilitate the addition of those service components in treatment.

RESEARCH DESIGN AND METHODS

This research project examined women's substance abuse from a critical theory perspective. The critical perspective rejects the notion of value free research and focuses on the ideologies that create injustice and deprivation for one group, while maintaining power and privilege for another (Guba, 1990). Critical theory advocates use of research to bring about social change. Furthermore, through the implementation of social change, critical theory aims to empower an oppressed group (Guba, 1990). Research employing this perspective, therefore, naturally assumes a position of bias in that it examines a social problem in light of a power relation.

This study examined the problem of female substance abuse with the view that the power ideology, patriarchy, and its infringement upon every area of women's lives, also impacts the design of treatment programs and delivery of service provisions to women within those programs. The research question was: "What action can be taken in
treatment programs to lessen women's use/abuse of chemical substances?" The researchers also hypothesized that, in a comparison of two outpatient programs accepting women who abuse both drugs and alcohol, a program incorporating components meeting needs unique to women will have higher completion rates for women than one that does not have gender sensitive components. Thus, the research explored program components, and completion rates of female clients. Additionally, the researchers explored the service provisions that treatment providers believe are important in meeting the needs of female clients.

The data was gathered by researchers in three parts. The first part consisted of the completion of a one-question survey and a face-to-face interview with program administrators from both programs. The survey: 1) explored the program administrator's perceptions of the importance of certain treatment components to women's program completion and recovery, and 2) provided data regarding components offered within each program. Face-to-face interviews explored: 1) what service components are included in their programs, and the perceived degree of success of each, and 2) what components they perceived are relevant to include in treating female clients.
The second part of the study consisted of a self-administered survey given to program staff regarding services they, as individuals, administer, services they felt would be relevant to administer to female clients, and general demographic information.

The third part of the study consisted of collection of secondary data from treatment program client files regarding demographic information, completion rates, and parental status. This study employed inductive reasoning, quantitative and qualitative methods of data gathering, and exploratory and descriptive approaches.

**Sampling**

The research examined treatment components of two substance abuse programs in San Bernardino County. The programs chosen for this study accept both male and female clients, offer outpatient services, and are either traditional or gender-sensitive in service orientation.

The sample population came from treatment program client statistics of adult females, who were 21 years old and older. A total of forty-four (44) client files were examined, twenty-two (22) from the sampling population of each treatment program. The research was obtained via nonprobability sampling.
A purposive sampling technique was employed to obtain client file data. A subset of the larger sample population was chosen non-randomly through the use of a designated study population for each program. Program administrators from each program, after being informed of the purpose of the research study, used their judgement to select the sample population. In this regard the sample population was purposively selected in an effort to yield the most comprehensive understanding for the exploratory and descriptive purposes of the study (Rubin and Babbie, 1993).

The sample population included treatment staff from both programs who were currently involved in the delivery of one or more service components, and were involved in treatment delivery to female clients for six months or longer. The six month requirement helped to support a greater insight, knowledge and understanding on the part of line staff as to program components and client needs. A total of five line staff participated in the study, three (3) from the gender-sensitive program and two (2) from the traditional program.

The sample population also included one program administrator from each program of study. A program administrators' experience and professional knowledge
further supported an enhanced depth of contextual, exploratory insights.

Data Collection Procedure and Instruments

Program Administrators were asked open- and close-ended questions. Administrators were asked to complete one close-ended survey question in which they ordinally ranked the importance of components the literature review suggests should be provided to women in treatment (See Appendix B).

Face-to-face interviews were also conducted with program administrators (See Appendix C). Open-ended questions addressed current program components and the degree of success for each, as well as questions regarding components not presently included in service provision, that respondents feel are nonetheless important in meeting women's treatment needs.

The program staff survey (see Appendix D) employed nominal and open-ended questions. Open-ended questions explored what services, not currently included in their program, respondents feel might be important in meeting women's treatment needs. Close-ended, nominal questions were employed to obtain demographic information such as gender, age, race, program orientation (gender-sensitive vs. traditional), length of employment, and educational level. For the purpose of identifying staff respondents with the
program by which they are employed, surveys were precoded "1" (gender sensitive) or "2" (traditional), and administered appropriately. Data regarding length of employment was obtained for descriptive purposes and to ensure that only those surveys of respondents employed for six months or more (a criteria outlined in the sampling section) were analyzed.

Secondary data related to client files was collected on a standardized data collection form (Appendix E) and included nominal measures regarding completion rates, length of time in the program, parental status, children in on-site day care, if applicable, age and race. The type of treatment program was primary to our hypothesis. Thus, for the purpose of identifying clients with the program from which they were/are receiving treatment, each data collection form was marked "1" (gender sensitive) or "2" (traditional), as appropriate.

All data collection was conducted at the treatment sites by the researchers. Data collection was spread over a nine-week period. The first part of the data collection with program administrators took a total of five weeks at both programs. The second portion with program line staff took approximately one week per program, and the client file data collection took about one week per program.
Due to the specific nature of the study, it was necessary for researchers to design a survey instrument for program administrators and line staff that reflected the variables to be studied. Similarly, a list of questions for face-to-face interviews was designed for program administrators. The variables relevant to the research included: the specific components currently offered and those that would be helpful to women in the programs examined, the efficacy of these components for women, and (for program line staff only) general demographic information. The survey instrument was pretested with twenty respondents, at least ten of whom have been involved in treatment programs either as participants or program staff.

The qualitative approach used interpretative techniques for analysis. Conceptualization was the first step of the analysis of data. The "open coding" process was used to discover successful treatment components which are needed for women in recovery. Categories were revealed in regards to their characteristics and dimensions from data sampling. Data was reduced by identifying treatment components for women and related concepts which were then categorized together. Categories were developed first in regards to their properties or characteristics, which were then
dimensionalized according to intensity, frequency and duration. The properties of each category were then placed on the dimensional continua for the development of profiles. These profiles represented the specific properties relevant to the contextual conditions of the lives of women in treatment. Properties and dimensions developed the basis for making relationships between categories and subcategories. This process was used to observe patterns in the data for comparison and enhanced the inclusion of related data samples (Strauss & Corbin, 1990).

Categorization of 1) the factors affecting women's program completion and recovery, 2) women's needs in treatment, 3) treatment provisions, and 4) societal and personal constraints that impinge on self-determination and participation in treatment programs were developed. This process fostered accuracy in developing subcategories. It was at this point of the analysis that a hypothesis more clearly emerged based on continued data analysis (Strauss and Corbin, 1990).

Axial coding was used to suggest and verify relationships between categories and subcategories (Strauss & Corbin, 1990). Our research study placed emphasis on the action/interactional strategies used to respond to women's substance abuse treatment needs and support for recovery.
Exploration of related strategies that are not included but are perceived as needed for supporting women's treatment needs and recovery rates, were examined. Emphasis was also placed on the consequences of action/interactional strategies in terms of successful program components and women's substance abuse completion and recovery. Researchers examined how the complexities of women's lives affect both factors.

Researchers examined differences and similarities in qualitative responses. A continuous process of comparing the hypothesis with the data provided findings that we used in the development of theory regarding the phenomenon of study. The final analysis offered a relevant theory and contextual data in terms of the research question (Strauss & Corbin, 1990).

The validity of the data was strengthened because the data gathering methods emphasized ordinal and open-ended survey questions and face-to-face interviews. A fuller context of program components was uncovered through face-to-face interviews with program administrators and a qualitative line staff survey questionnaire. The face-to-face interviews also offered the flexibility to clarify and allow expansion of respondent's answers about a given topic (Babbie, 1992). The qualitative self-administered survey
provided an adequate scope of inquiries regarding treatment components and staff perceptions about their efficacy.

An additional strength of the design lies in the fact that it examines both treatment issues and client needs. The research is inclusive in that it examined programs which offer treatment for all types of substance abusers. The sample population was sufficient for supporting the researchers' exploratory efforts. The face-to-face interviews and qualitative survey questions increased the contextual and in-depth qualities of data gathering and sampling techniques. The secondary data analysis strengthened the validity of the research instrument and conclusions obtained by comparing and verifying accuracy levels of related research findings. Also, it provided further descriptive data on variables of inquiry.

A weakness in the design involves the use of a nonprobability sampling method which reduces the reliability of the research findings and does not allow for estimating the amount of sampling error present. Further, the sampling population cannot claim generalizability to the population from which it was selected.

Protection of Human Subjects

Researchers obtained consent to gather data from programs by program directors (Appendices F & G).
Researchers also obtained a signed informed consent from each line staff respondent prior to survey administration (Appendix H). Immediately following data collection, researchers debriefed respondents as to the nature of the study, offered supportive feedback, if necessary, and provided a resource for respondents who had further questions or concerns (Appendix I).

No names or other identifying data of individual program line staff was obtained. A number was randomly assigned to each survey. Researchers collected no information which would link an individual program staff person to any data obtained. However, surveys were marked 1 or 2 to identify by which program the line staff were employed.

Clients were not interviewed, and no personal involvement on their behalf was required. No names or other identifying data of individual clients was obtained. A number was randomly assigned to each client file. Researchers obtained no information which would link an individual client to any data obtained. Therefore, the potential for psychological or emotional harm to any client was eliminated.
RESULTS

This research design incorporated both a quantitative and qualitative analysis. The analysis was intended to 1) show whether there is a correlation between the type of program (gender-sensitive or traditional), and woman's program completion rates, and 2) identify treatment components that will meet the needs of women substance abuser, and 3) analyze program components and the success of their treatment services.

Qualitative Findings

The qualitative procedures for analysis were initiated with the development and identification of concepts or ideas related to the program administrators' responses. These concepts were then formed into categories which showed similarities and dissimilarities. The categories helped to highlight program treatment components which support women's program completion and positive recovery. This analysis used "Grounded Theory" and interpretative procedures to recognize data patterns, and to support development of conceptualizations, theory, and a working hypothesis (Strauss and Corbin, 1990).

The face-to-face program administrator interviews were held at the Inland Behavioral Services and Cedar House
Rehabilitation Center. One program administrator from each program participated.

Program Administrator Treatment Component Ratings

Our research examined fourteen program treatment components that have been found in the literature to support women's treatment needs. The program treatment components studied are the following: (1) individualized sessions, (2) women's support groups, (3) mental health services, (4) female only groups, (5) child care services, (6) family therapy, (7) parenting class, (8) career and educational services, (9) medical and pediatric services, (10) social activities, (11) long term aftercare, (12) outreach services, (13) coed groups and activities, and (14) staff training for women's treatment needs.

A significant finding was that both program administrators perceived that the treatment components studied within their programs were, to some degree, successful. The gender sensitive program variables noted by program administrators as very successful were: (1) child care service, (2) women's support group, (3) long term after care, (4) staff training for women's treatment needs, (5) individualized sessions and (6) female only groups.

The gender sensitive program findings indicated that the following components were successful: (1) medical and
pediatric services, (2) mental health services, (3) parenting classes, (4) family therapy, (5) career and educational services, (6) social activities, and (7) outreach services.

The traditional program findings indicated that the following components were very successful: (1) parenting classes, (2) coed groups, and (3) individualized sessions.

The traditional program findings showed that the following treatment components were successful: (1) women's support groups, (2) family therapy, and (3) long term after care.

These findings indicate a significant difference in responses between those components found successful and very successful within the gender sensitive program. Additionally, findings show that women in treatment receive more supportive services to meet their needs within the gender sensitive program.

Program Administrator Similarities

Both program administrators' responses showed a high level of agreement for providing women with the following treatment components: Child Care Service, Individualized Sessions, Parenting Classes, Family Therapy, Female Only Groups, and Women's Support Groups. Responses also showed a high level of agreement for the therapeutic aspects that
these treatment components offer women for program completion and recovery.

Child Care provisions were found to alleviate a major barrier to women’s program participation and stressors associated with parenting. Individualized Treatment Sessions were supportive of women’s self expression and the therapeutic process, as it relates to abuse and other sensitive issues. Parenting classes and family therapy were found to increase women’s self esteem, coping skills, and healthy family relationships. Female only treatment groups and women’s support groups offered women mutual aide and enhancement for problem solving strategies unique to women’s issues, as they relate to maintaining recovery. The Long Term Aftercare services were found to reinforce healthy coping and personal growth strategies to support sober living patterns.

Program Administrator Dissimilarities

There was a significant disparity in the number of treatment components provided by the gender sensitive program as compared to the traditional program. Table 1 below indicates those treatment programs which are provided for each program of study.
Chart 1

Treatment Component Provisions by Program Type

<table>
<thead>
<tr>
<th>Traditional Program</th>
<th>Gender-Sensitive Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individualized Sessions</td>
<td>Individualized Sessions</td>
</tr>
<tr>
<td>Family Therapy</td>
<td>Family Therapy</td>
</tr>
<tr>
<td>Parenting Classes</td>
<td>Parenting Classes</td>
</tr>
<tr>
<td>Long Term After Care</td>
<td>Long Term After Care</td>
</tr>
<tr>
<td>Women’s Support Groups</td>
<td>Women’s Support Groups</td>
</tr>
<tr>
<td>Coed Groups</td>
<td>Child Care Services</td>
</tr>
<tr>
<td></td>
<td>Mental Health Services</td>
</tr>
<tr>
<td></td>
<td>Female Only Groups</td>
</tr>
<tr>
<td></td>
<td>Social Activities</td>
</tr>
<tr>
<td></td>
<td>Outreach Services</td>
</tr>
<tr>
<td></td>
<td>Staff Trng for Women’s Needs</td>
</tr>
<tr>
<td></td>
<td>Job and Educational Services</td>
</tr>
</tbody>
</table>

The greater number of treatment components for the gender sensitive program shows a significant difference for the capacity to provide needed services for women.

The gender sensitive program responses showed that services which are provided within their program, but are not provided in the traditional program, are critical to women. Findings indicate that these services provided preventive and intervention services which are directed to meeting women’s treatment needs. These needs were in context
to their lives so that services which incorporate children and family members were considered as very important to women's recovery. Furthermore, the services were found to consider survival, health, cultural and human diversity, and social support needs for women.

The analyses showed a dissimilarity between both programs' orientations towards coed treatment groups. The traditional program responses showed that male and female self expression and interaction within coed treatment groups enhanced alternative strategies for recovery. In addition to this, coed treatment groups help develop healthy male and female relationships that are required for women's recovery. The gender sensitive program responses suggest that coed treatment groups are not necessary for women's recovery, as women make healthy life choices without male involvement. Responses also pointed to the importance of women making relationship changes that do not include the male partner, to maintain a woman's therapeutic progress.

Program Administrators' Needs Assessment

The gender sensitive program administrator responses indicated the following needed components that are not provided in his program: (1) coed treatment groups, (2) program funding, and (3) advanced pediatric services. Findings indicated that coed groups were needed because men
are often left out of the therapeutic process in programs which serve women. Also, male and female relationships are a major influence for women's positive recovery outcomes. The program funding component was needed for furthering the educational opportunities for the women and children served. Additionally, this component was required to enhance women's computer skills for career advancement. The advanced pediatric services were needed to prevent and intervene in the health problems that are often associated with women's drug abuse during pregnancy. Furthermore, women substance abusers are often in need of information that will promote their children's health and development.

The traditional program administrator findings indicated the following components are needed but are not provided: (1) female only groups, and (2) child care service. The female only groups were needed to support women's ability to express gender issues that are associated with substance abuse recovery. Moreover, the female only groups were found as essential for women's therapeutic involvement as it relates to other sensitive issues. Child care services were needed to respond to one of women's most important concerns while in treatment: the care and health of their children. Women were found to become more motivated for substance abuse treatment when they are
assured that their children are properly cared for.

Line Staff Needs Assessment

The line staff self administered questionnaire, (see Appendix D) was given at each program site. The gender sensitive program had three participants and the traditional program had two. The responses for five open-ended questions offered validity for the previous findings.

Both program line staff expressed similar concerns and agreement for improving service provisions for the following: (1) women’s abuse issues, (2) marital and family problems, (3) parenting deficits, (4) health issues, (5) case management services for community resource referrals and (6) perinatal care.

Line staff agreed that the following intensive services were needed to support women in recovery: (1) financial planning, (2) job placement training, and (3) educational advancements for GED and college. These components were found to be crucial to a woman’s ability to make life changes that support recovery efforts.

Dissimilarities in the findings of line staff were that one traditional program respondent felt there were no differences in treatment needs between men and women. However, the other traditional program respondent expressed that women do require interventions for domestic and sexual
abuse issues. The gender sensitive line staff placed an emphasis on providing the following treatment program components which were not stressed or addressed by the traditional program responses: 1) longer term aftercare programs that are monitored and have individualized counseling 2) educational components which further a woman’s understanding of the association between substance abuse, gender role constraints and historical social treatment differentials.

Summary of Program Personnel Findings

Findings from the program administrators’ responses and those of the line staff validate that successful treatment components must address women’s needs in context to their life. The needed services were found to support women’s engagement process for treatment. Ongoing services that are needed throughout treatment and Long Term After Care Services were found to be supportive of women’s program completion. Further, the services provided that meet women’s needs for recovery were found to have interventions that were intense, frequent, and had a long duration.

The needs of women were found to correlate with the conditions of women’s social constraints. These social constraints were found in the areas of relationships, education and career, medical and mental health care,
economic security, social supports, gender roles, sexual and domestic abuse, and child care provisions. It was found that women require responsive social support services which alleviate these constraints within the treatment program for recovery.

The consequences of not affording women services that meet their treatment needs were found as barriers to self independence for meeting their survival, relationship, and recovery needs. Findings show a strong correlation between providing women with needed services and enhanced capacity for program participation and recovery efforts.

The final qualitative analyses support the hypothesis that if women have access to needed service provisions, they will have better substance abuse recovery outcomes. Women face historical, social, and cultural oppressive forces which must be recognized to support sustained recovery.

**Quantitative Findings**

Computers were utilized for quantitative analysis using the EPI software program. All raw data was assembled and nominal answers assigned fixed, numerical codes for data entry. All data entry and analyses were conducted by the researchers.

In the quantitative portion of this study, researchers were primarily concerned with the completion rates for
female clients in programs "1" (gender-sensitive) & "2" (traditional). To examine correlations between type of program and a client's negative or positive completion rates, researchers collected nominal data from the client files of both treatment programs regarding completion rates. Data, in terms of actual weeks clients participated in the program, was obtained to determine whether clients completed the program or not. The "gender-sensitive" program was coded "1"; the "traditional" program "2". Completion was coded "1" for "yes", if the treatment program was completed, or "2" for "no", if the treatment program was not completed. Researchers then conducted single table analyses which yielded the following:

**TABLE 1**

**Program Completion Rates by Program Type**

<table>
<thead>
<tr>
<th>PROGRAM TYPE</th>
<th>PGM COMPLETION</th>
<th>GENDER-SENSITIVE</th>
<th>TRAD.</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>12</td>
<td>8</td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>NO</td>
<td>10</td>
<td>14</td>
<td></td>
<td>24</td>
</tr>
<tr>
<td>TOTAL</td>
<td>22</td>
<td>22</td>
<td></td>
<td>44</td>
</tr>
</tbody>
</table>

**Chi-Squares** | **P-values**
--- | ---
Uncorrected: 1.47 | 0.22587236
Mantel-Haenszel: 1.43 | 0.23122121
Yates corrected: 0.82 | 0.36372233
A chi-square analysis was conducted to determine the significance of the correlation between type of program and completion rates, since this is the appropriate non-parametric test for use with nominal variables (Rubin & Babbie, 1992). Researchers looked for a p-value of .05 or less with a 95% confidence level. Chi-square values indicated there is no significance between the type of program and a positive or negative impact in completion rates. Therefore, we can accept the null hypothesis that any difference in the completion rates between program types is caused by chance.

The literature has shown that female substance abusers with children find it difficult to start and remain in treatment programs that do not provide child care. To examine correlations between parental status, program type (both 1 & 2) and completion rates, researchers collected nominal data from the client files of both treatment programs. Parental status was coded "1" for "yes", if the client is a parent, and "2" for "no", if the client is not a parent. Program completion was again coded "1" for "yes", if the client completed the program, and "2" for "no" if the client did not complete the program. Multivariate analyses using the above variables yielded the following results:
### TABLE 2

The Effect of Parental Status on Program Completion Within the Gender Sensitive Program

<table>
<thead>
<tr>
<th>PARENTAL STATUS</th>
<th>YES</th>
<th>NO</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>PARENTING</td>
<td>12</td>
<td>10</td>
<td>22</td>
</tr>
<tr>
<td>NONPARENTING</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>12</td>
<td>10</td>
<td>22</td>
</tr>
</tbody>
</table>

### TABLE 3

The Effect of Parental Status on Program Completion Within the Traditional Program

<table>
<thead>
<tr>
<th>PARENTAL STATUS</th>
<th>YES</th>
<th>NO</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>PARENTING</td>
<td>7</td>
<td>14</td>
<td>21</td>
</tr>
<tr>
<td>NONPARENTING</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>8</td>
<td>14</td>
<td>22</td>
</tr>
</tbody>
</table>

Chi-Squares  P-Values
Uncorrected: 1.83 0.17573434
Mantel-Haenszel: 1.75 0.18587673
Yates corrected: 0.08 0.77170590

Fisher exact: 1-tailed P-value: 0.3636364
2-tailed P-value: 0.3636364

39
A chi-square analysis was conducted and a Fisher exact analysis was automatically obtained if the values in any given cell were less than 5, rendering the chi-square analysis invalid, as was the case here. The two-tailed p-value for the Fisher exact was then analyzed, since it is the test applicable to hypothesis testing for which the direction (positive or negative) is known. Researchers looked for a p-value of .05 or less with a 95% confidence level. Fisher exact indicates the p-value for both the one and two-tailed tests are insignificant, or above .05. Therefore, we can accept the null hypothesis. Results indicate that any relationship between parental status, program completion and program type is caused by chance.

The researchers also hoped to validate the literature’s findings that certain components are important to meeting women’s needs in treatment, as well as supporting their successful program completion and sustained recovery. Program Administrators were asked to rank fourteen treatment components from (1) most important to (14) least important. Ordinal ranking yielded the following results:

**CHART 2**

**Treatment Components as Rank-Ordered by Program Administrators**

<table>
<thead>
<tr>
<th>Traditional Program</th>
<th>Gender-Sensitive Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>1=Individual Sessions</td>
<td>1=Female Only Groups</td>
</tr>
</tbody>
</table>
CHART 2 (cont’d)

**Treatment Components as Rank-Ordered by Program Administrators**

<table>
<thead>
<tr>
<th>Traditional Program</th>
<th>Gender-Sensitive Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>2=Women’s Support Groups</td>
<td>2=Individual Sessions</td>
</tr>
<tr>
<td>3=Child Care</td>
<td>3=Mental Health Services</td>
</tr>
<tr>
<td>4=Female Only Groups</td>
<td>4=Child Care</td>
</tr>
<tr>
<td>5=Family Therapy</td>
<td>5=Parenting Class</td>
</tr>
<tr>
<td>6=Job &amp; Educ. Svs.</td>
<td>6=Med. &amp; Pediatric Svs.</td>
</tr>
<tr>
<td>7=Parenting Class</td>
<td>7=Women’s Support Groups</td>
</tr>
<tr>
<td>8=Mental Health Services</td>
<td>8=Family Therapy</td>
</tr>
<tr>
<td>9=Medical &amp; Pediatric Svs.</td>
<td>9=Job &amp; Educational Svs.</td>
</tr>
<tr>
<td>10=Long Term Aftercare</td>
<td>10=Social Activities</td>
</tr>
<tr>
<td>11=Social Activities</td>
<td>11=Long Term Aftercare</td>
</tr>
<tr>
<td>12=Outreach Services</td>
<td>12=Coed Groups/Events</td>
</tr>
<tr>
<td>13=Basic Living Skills</td>
<td>13=Basic Living Skills</td>
</tr>
<tr>
<td>14=Coed Groups/Events</td>
<td>14=Outreach Services</td>
</tr>
</tbody>
</table>

Results show that program administrators ranked five (5) or 70% of the same components within the first half of the components listed. This indicates a strong agreement that Individual Treatment Sessions, Female Only Groups, Women’s Support Groups, Child Care, and Parenting Classes are important to women in treatment. Similarly, program administrators ranked five (5) or 70% of the same components within the second half of the components listed. This,
again, indicates a strong agreement that Long Term Aftercare, Social Activities, Outreach Services, Coed Groups and Activities, and Training for Women's Needs are of lesser importance to women in treatment.

Frequencies from client file data were run for descriptive purposes to delineate age and race, and to ensure that those clients included in the analysis were 21 years of age or older (criteria previously outlined in the sampling section). Age was delineated in real numbers (See Appendix A, page 44). The two most common ages in this sampling frame were twenty-nine and thirty-one. 77% of the participants were between the ages of twenty-three (23) and thirty-four (34).

Race was coded "1" for Caucasian, "2" for African-American, "3" for Hispanic, "4" for Asian, "5" for Pacific Islander, "6" for Native American, "7" for Mixed Race, and "8" for Other. As indicated by the following table, the most common race in the client sampling population is Caucasian at 61.4%.
Table 4

Race of Clients from Client File Sample

<table>
<thead>
<tr>
<th>RACE</th>
<th>CUM.</th>
<th>PERCENT</th>
<th>CUM.</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAUC</td>
<td>27</td>
<td>61.4%</td>
<td>61.4%</td>
</tr>
<tr>
<td>AFRICAN AMERICAN</td>
<td>7</td>
<td>15.9%</td>
<td>77.3%</td>
</tr>
<tr>
<td>HISPANIC</td>
<td>9</td>
<td>20.5%</td>
<td>97.7%</td>
</tr>
<tr>
<td>OTHER</td>
<td>1</td>
<td>2.3%</td>
<td>100.0%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>44</td>
<td>100.0%</td>
<td></td>
</tr>
</tbody>
</table>

Total Sum Mean Variance Std Dev Std Err
44 76 1.727 1.598 1.264 0.191

Minimum 25%ile Median 75%ile Maximum Mode
1.000 1.000 1.000 2.000 8.000 1.000

DISCUSSION

The qualitative research concurs with the hypothesis that programs which provide gender sensitive treatment components enhance women’s capacity for program completion and sustained recovery. Significantly, findings showed that all program treatment components studied were successful or very successful for supporting women’s therapeutic progress. This strongly indicates that benefits are derived from providing a broad range of need based services for women.

The differences in gender responsibilities and roles in the context of women’s lives were found to relate to their treatment needs for recovery. Child Care Service provisions were emphasized by both programs as a major asset for
freeing women from role constraints, enabling their program participation and recovery efforts. Engaging and retaining women in treatment were significantly associated with services that strengthened their family or significant other relationships. Findings pointed to the primacy of women’s relationships with significant others as being highly influential for recovery progress. Similarly, service provisions which afforded women with emotional support, mutual aide, and a nonthreatening environment for addressing abusive issues were found as vital. Other significant findings related to enhancing women’s social opportunities for financial stability, access to social support systems, educational advancements, and long term after care service provisions.

Our research findings supported those in the literature which suggest that women need a high level of gender sensitive services. Significant findings showed that the gender sensitive program offered women thirteen treatment components, while the traditional program offered six. Additionally, the gender sensitive program ranked six service provisions as very successful. The traditional program indicated that only one (Coed Groups) was very successful.
The success of the service provisions studied aligned with the literature findings which indicate that women require a great deal of social support for recovery. Research findings related women's historical oppression and associated social constraints to their treatment needs. Significant findings showed that women require interventions for domestic and sexual abuse. Also, intensive service provisions are needed to stabilize women economically and emotionally, thus affording greater social opportunities for independence. Addressing these issues was found to positively affect women's abilities to meet their survival, relationship, self independence, and recovery needs.

Recognition of women's treatment needs in relation to societal oppression, then, is critical for removing barriers to therapeutic progress in context to women's life experiences. Findings indicate that the complexity of women's lives and responsibilities must be recognized and addressed within treatment programs. The literature states that women are often not assessed properly for substance abuse and that case finding for women is poor. The researchers speculated that providing a relevant continuum of services may strongly depend on the program's commitment to a multidimensional assessment process. In this way, women's historical vulnerability to social constraints,
oppression, isolation, and illicit drug use patterns are considered in context to their lives and cultural orientations.

The findings suggest that underrepresentation of women in substance abuse treatment may be relative to women’s low expectations for getting their needs met. An associated factor is a lack of social recognition for gender role constraints. Women’s parenting and survival stressors render them vulnerable to a perceived helplessness. These factors would logically reduce women’s motivation for treatment involvement. The literature shows that historically, women’s social opportunities for personal development are undermined through power relations in all major institutions and systems. Also, women’s gender roles constrain their recovery efforts. Treatment programs that are sensitive to these issues help to empower women through responding to their needs. These efforts enhance the generalization of women’s empowerment in treatment to all areas in their lives, which supports them in taking responsibility for recovery.

Researchers also have speculated that treatment programs are limited from providing a continuum of service provisions for women, due to a lack of funding and community resources. This may be due to the historical oppression of women through the political and economic
systems. The literature indicates that women are usually excluded from these systems and have little power to be responded to or even heard. Findings for the gender sensitive program denoted that these factors present system barriers to women's service needs, which must be addressed to further support women's substance abuse recovery.

In the quantitative portion of our study, we hypothesized and hoped to show a relationship between having gender-sensitive components in a treatment program and women's higher completion rates. Because the literature indicates a strong need for child care for women, and because most of the clients from our sample were parents, we also hoped to show a higher completion rate among parenting women in treatment who received day care provisions. However, the results indicated no significant differences in completion rates in either program, among parenting or non-parenting females (See page 36, Table 2). It is interesting to note that the literature was supported by the program administrators, who in ranking the importance of particular components to women in treatment, indicated a strong need (at "3" and "4"), for women to have day care provisions. Findings indicated that most of the females in the sample population were parents.
It is noteworthy that completion rates for women were low in both programs. Both program administrators indicated that, while their programs do offer family therapy, the significant others in these client's lives do not participate. Researchers speculate that this factor may support assertions made in the literature that lack of participation from significant others decreases women's participation and completion in drug treatment programs. This may explain why completion rates for both programs were low.

Program administrators also supported the literature's contention that females need individualized, as well as gender-specific therapy and support groups. Individual Sessions, Female Only Groups, and Women's Support Groups were all ranked by program administrators in the top seven, with most in the top four.

A primary limitation of the study lies in the small sample size and the nonrandom selection of files. The design was also limited in terms of gender and focus such that results obtained were not, for the most part, relative to male populations. Much of the research was not pertinent to a younger population of substance abuse, since issues examined were largely those experienced by adults facing adult responsibilities. However, it was sufficient to the
extent that insightful and descriptive results can be used to help broaden treatment programs that the literature shows are largely male-oriented.

Further research is warranted. A larger, random sample may show some correlations and prove to be more generalizable to female clients outside the particular programs of study. Additionally, the perspective of the female clients themselves could uncover some needs not mentioned by line staff.

Program administrators indicated that a large majority of the women in treatment were court-mandated to participate and were, therefore, not participating out of their own desire. They also indicated that their outreach programs were not very strong. Researchers agree that a follow-up study could be conducted to develop a profile on women who don’t complete treatment programs. This study would include an examination of the context of these women’s lives, including the stressors that impinge upon their completion of substance abuse programs. Programs could then develop components, including follow-up outreach, that encourage women’s engagement in treatment. While our study concerned itself with women in general, it is noteworthy that the majority of women who entered treatment at both the facilities of study were Caucasian. Researchers feel that a
follow-up study might also uncover some of the reasons why women of color are not entering treatment programs.

Conclusions and Implications for Social Work Practice

Although social workers at the master's level or higher comprise only 5% of the nation's total staff providing substance abuse services (Magura, 1994), social work is in a key position to assist this population. At the micro level, social workers must advocate on behalf of clients by offering training and consultation to traditional drug treatment programs that fail to address women's needs (Abbott, 1994; Blume, 1990; Nelson-Zlupko et al, 1995). They must also educate one another and those in other helping professions, as to the impact of gender issues on substance abuse and treatment, and the need to refer clients to programs that support those needs (Magura, 1994).

At the macro level, social workers can actively work to influence changes in social policies that oppress women and contribute to chemical dependency. Policies addressing such issues as sexual harassment, interpersonal violence, and economic inequality must be developed and supported (Nelson-Zlupko et al, 1995). Additionally, social workers must advocate for funding that addresses women's unique needs by educating legislators and program administrators. Blume (1990) states that, rather than the traditional criminal
prosecution of pregnant alcohol- and drug-dependent women, the appropriate public policy to protect women and their children must include aggressive outreach to women of childbearing age and those already pregnant, adequate alcoholism and drug abuse screening in all obstetric practices, adequate and accessible prenatal care, and accessible chemical dependency treatment.

It is the hope of the researchers that the results of this data will enlighten helping professions, will foster the addition of programs/program components compatible with the needs of women substance abusers, and will thereby empower female clients.
## APPENDIX A

### Age of Clients from Client File Sample

<table>
<thead>
<tr>
<th>AGE</th>
<th>FREQ.</th>
<th>PERCENT</th>
<th>CUM.</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>1</td>
<td>2.3%</td>
<td>2.3%</td>
</tr>
<tr>
<td>22</td>
<td>1</td>
<td>2.3%</td>
<td>4.5%</td>
</tr>
<tr>
<td>23</td>
<td>3</td>
<td>6.8%</td>
<td>11.4%</td>
</tr>
<tr>
<td>24</td>
<td>3</td>
<td>6.8%</td>
<td>18.2%</td>
</tr>
<tr>
<td>25</td>
<td>1</td>
<td>2.3%</td>
<td>20.5%</td>
</tr>
<tr>
<td>26</td>
<td>1</td>
<td>2.3%</td>
<td>22.8%</td>
</tr>
<tr>
<td>27</td>
<td>2</td>
<td>4.5%</td>
<td>27.3%</td>
</tr>
<tr>
<td>28</td>
<td>3</td>
<td>6.8%</td>
<td>34.1%</td>
</tr>
<tr>
<td>29</td>
<td>5</td>
<td>11.4%</td>
<td>45.5%</td>
</tr>
<tr>
<td>30</td>
<td>3</td>
<td>6.8%</td>
<td>52.3%</td>
</tr>
<tr>
<td>31</td>
<td>5</td>
<td>11.4%</td>
<td>63.6%</td>
</tr>
<tr>
<td>32</td>
<td>3</td>
<td>6.8%</td>
<td>70.5%</td>
</tr>
<tr>
<td>33</td>
<td>2</td>
<td>4.5%</td>
<td>75.0%</td>
</tr>
<tr>
<td>34</td>
<td>3</td>
<td>6.8%</td>
<td>81.8%</td>
</tr>
<tr>
<td>35</td>
<td>1</td>
<td>2.3%</td>
<td>84.1%</td>
</tr>
<tr>
<td>37</td>
<td>2</td>
<td>4.5%</td>
<td>88.6%</td>
</tr>
<tr>
<td>38</td>
<td>1</td>
<td>2.3%</td>
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### Statistics

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APPENDIX B
PROGRAM ADMINISTRATORS’ RANK-ORDERED
PROGRAM COMPONENTS

1. PLEASE RANK THE FOLLOWING COMPONENTS, FROM “1” –
“14”, ACCORDING TO HOW IMPORTANT YOU FEEL THEY ARE TO WOMEN
IN TREATMENT “1” BEING THE MOST IMPORTANT AND “14” THE
LEAST?

-- Child Care Service Provisions
-- Parenting Classes
-- Individualized Treatment Sessions for Women
-- Mental Health Services
-- Female-only Treatment Groups and Activities
-- Coed Treatment Groups/Activities
-- Social Activities for Women within the Program
  and Community
-- Outreach Services
-- Staff Training for Meeting Women’s Specific
  Treatment Needs
-- Services for Job and Educational Opportunities,
  and Vocational Training
-- Family Therapy Services for Female Clients
-- Long-Term After Care and Relapse Prevention
  Services
-- Medical and Pediatric Services
-- Women’s Support Groups
1. How successful do you feel the following components are in supporting women's program completion and/or sustained recovery within your treatment program?

-- Child Care Service Provisions
-- Parenting Classes
-- Individualized Treatment Sessions for Women
-- Mental Health Services
-- Female-only Treatment Groups and Activities
-- Coed Treatment Groups/Activities
-- Social Activities for Women within the Program and Community
-- Outreach Services
-- Staff Training for Meeting Women's Specific Treatment Needs
-- Services for Job and Educational Opportunities, and Vocational Training
-- Family Therapy Services for Female Clients
-- Long-Term After Care and Relapse Prevention Services
-- Medical and Pediatric Services
-- Women's Support Groups

2. What components do you feel are needed in treatment programs that are not currently provided? Why?
Please answer a few questions about yourself:

AGE: __

GENDER: Male __ Female __

ETHNICITY: Caucasian __ African American __ Asian __
Hispanic __ Pacific Islander __ Native American __
Mixed Race __ Other __________________

LENGTH OF EMPLOYMENT: 3-5 Months __ 6-12 Months __ YEARS __

POSITION: ______________________

EDUCATIONAL LEVEL: Less than 12 years __ H.S. Diploma __
Some college __ B.A. Degree __ Master’s Degree __ Ph.D. __

Do you have a professional certificate or license? Y __ N __

If yes, what is it? ________________________________

1. In working with female substance abusing clients, what other special social, emotional, and financial needs do they have, in your opinion, that are different from the men you treat?

__________________________________________________________________________________

__________________________________________________________________________________

2. What other treatment approaches, aside from those used currently, would you suggest using which are specific to female substance abusing clients?

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________
3. What educational programs not provided currently do you feel would benefit female substance abusing clients?

4. Are there aftercare services not provided currently that you feel would benefit female substance abusing clients?

5. Are there social activities not provided currently that you feel women would find helpful as a supplement to their treatment?
APPENDIX E
CLIENT DATA FORM

1. PROGRAM TYPE: 1__ 2__

2. RACE: CAUCASIAN__ AFRICAN-AMERICAN__ HISPANIC__
   ASIAN__
   PACIFIC ISLANDER__ NATIVE AMERICAN__ MIXED RACE__
   OTHER (PLS SPECIFY)______________________________

3. AGE: __

4. PARENTAL STATUS: Y__ N__

5. CHILDREN IN ON-SITE DAY CARE: Y__ N__

6. TIME IN THE PROGRAM: (No. Of weeks) __

7. PROGRAM COMPLETION: Y__ N__
APPENDIX F
CEDAR HOUSE PROGRAM CONSENT FORM

Human Subjects Review Board
California State University, San Bernardino
5500 University Parkway
San Bernardino, CA

To Whom It May Concern:

I herein give my consent for Judyth L. Scott and Linda Pettine to conduct a study at Cedar House Rehabilitation Center as part of a research project for the Masters Degree in Social Work. I understand that this study will involve a comparative analysis of treatment program approaches in an attempt to ascertain their efficacy in supporting women's program completion and sustained recovery.

I also understand that data collection will involve the use of client statistics and/or files and completion of a questionnaire by program line staff. I understand that this project will take approximately four weeks to complete. I am assured that the information collected will be kept anonymous and confidential and that the Human Subject Review Board, through the Department of Psychology at California State University, San Bernardino, will approve the project prior to data collection.

I understand that I may contact appropriate faculty at the Social Work Department if I have questions or concerns, and that I am free to withdraw my consent to all or any portion of the project during data collection. I further understand that I will be debriefed following completion of the project as to the results obtained.

Sincerely,

Bill Helring, Executive Director
Cedar House Rehabilitation Center

Date
APPENDIX G
INLAND BEHAVIORAL SERVICES
PROGRAM CONSENT FORM

Human Subjects Review Board
California State University, San Bernardino
5500 University Parkway
San Bernardino, CA

To Whom It May Concern:

I herein give my consent for Judyth L. Scott and Linda Pettine to conduct a study at Inland Behavioral Services as part of a research project for the Masters Degree in Social Work. I understand that this study will involve a comparative analysis of treatment program approaches in an attempt to ascertain their efficacy in supporting women's program completion and sustained recovery.

I also understand that data collection will involve the use of client statistics and/or files and completion of a questionnaire by program line staff. I understand that this project will take approximately four weeks to complete. I am assured that the information collected will be kept anonymous and confidential and that the Human Subject Review Board, through the Department of Psychology at California State University, San Bernardino, will approve the project prior to data collection.

I understand that I may contact appropriate faculty at the Social Work Department if I have questions or concerns, and that I am free to withdraw my consent to all or any portion of the project during data collection. I further understand that I will be debriefed following completion of the project as to the results obtained.

Sincerely,

Ed Williams, Director
Inland Behavioral Services

Date
Dear Participant:

Thank you for your willingness to participate in a study which explores the success of different approaches to the treatment of women substance abusers. This study is being conducted by Judyth Scott and Linda Pettine, Masters students in the Department of Social Work at California State University, San Bernardino. This study has been approved by the Human Subjects Review Board, Department of Psychology, California State University, San Bernardino.

You will be asked to complete a questionnaire. None of the questions are personal in nature. Some do ask your opinions, based on your experience, about the success of specific service provisions in helping women with substance abuse problems.

We will not be able to link your answers directly or indirectly to you in any way. The questionnaires will be kept private and confidential, and will be accessible only to the researchers.

You are under no obligation to participate in this study, and you may decline to continue participation at any time, or you may decline to answer any question with which you are uncomfortable. The entire questionnaire should take no more than 30 minutes to complete. Please give your consent to participate in this study by signing your name in the blank provided at the bottom of this page.

If you have any questions you may contact Judyth Scott at (909) 387-5182, or Linda Pettine at (909) 387-5367. THANK YOU AGAIN for your participation in this study.

Sincerely,

Judyth L. Scott

Linda Pettine

Study Participant __________________________ Date ____________
DEBRIEFING STATEMENT
APPENDIX I

Thank you for your participation in this study. The information you have given us is greatly appreciated. Your answers will help us to learn more about the service components that are most effective in the treatment of women substance abusers.

We wanted to explore whether the inclusion of specific gender sensitive components would positively impact women in treatment. We hypothesized that gender sensitive components would support women's higher program completion rates and sustained recovery.

To ensure anonymity, individual results will not be available. However, you may obtain a summary of our findings in June through the Department of Social Work at California State University, San Bernardino. If you would like a summary of the conclusions of this study, or have any further questions or concerns, you may contact the researchers, Judyth Scott or Linda Pettine, at (909) 387-5182 or (909) 387-5367, respectively. You may also contact Dr. Morley Glicken in the Department of Social Work at (909) 880-5501.

Sincerely,

Linda Pettine
Masters Degree Candidate

Judyth L. Scott
Masters Degree Candidate


