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DEPRESSION AND ITS CAUSES IN WOMEN RECOVERING
FROM SUBSTANCE ABUSE

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

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

by
Angelica Silvia Garcia
Coralyn Finlayson McCabe
June 2002


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Approved by:


Rachel Estrada, L.C.S.W. Faculty
Supervisor Social Work

5/24/02
Date


Dolores Pierce, Director of Family
Services New House Incorporated


Dr. Rosemary McCaslin,
M.S.W. Research Coordinator

ABSTRACT

The purpose of the study was to determine the extent environmental problems such as family history of substance abuse, loneliness and lack of support contribute to high levels of depression for substance abusing women seeking recovery in residential treatment facilities. A survey was administered consisting of 37 questions and the center for Epidemiologic Studies-Depressed Mood Scale (CES-D). The data was analyzed using quantitative research methods.

The findings of the study indicate high levels of depression for those women who reported that they grew up in an environment laden with substance abuse. In addition, loneliness and lack of support were found to be significant predictors of depression among recovering women.

Substance-abusing women are a unique population, with unique treatment needs. It is important for social workers and other helping professionals to understand and consider the problems women face when seeking recovery. Treatment that focuses on environmental problems and depression will greatly increase substance-abusing women's chances for long-term sobriety.

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CHAPTER ONE

INTRODUCTION

Problem Statement

The number of women suffering from alcoholism and/or drug addiction are staggering. Many of these women are finding their way into the treatment and recovery community. It is believed by some that substance abuse has been the woman's answer to other unresolved issues. A primary issue facing women in recovery is depression. Depression has many possible causes. Precipitating factors include issues related to their children such as Child Protective Services involvement, and childcare, loneliness, suicide, domestic violence, and sexual abuse and assault. Women in recovery may have little or no education, limited work experience or job skills, lack of transportation, and legal concerns. When these issues are not addressed during a woman's recovery process they become real barriers to recovery. By removing problematic substance use, women in recovery have no "pain killer" to defend against the emotional pain of living with these issues.

Because of these barriers, women who abuse substances should be considered a unique population with treatment

plans designed especially for them based on their special needs and problems. Women who are part of an intensive residential recovery program that incorporates treatment for depression and recognition of issues surrounding personal and social development into their curriculum may have fewer relapses than those who receive simple detoxification services and/or generic 12-step recovery. Women would benefit from extra supportive services to facilitate long-term sobriety. Women face a continuous uphill battle as they "recover from recovery." Recovery is a long painful process of facing the reality of their past alcohol/drug abuse, lost dreams, lost relationships, and the shame and guilt in realizing the damage that has occurred to themselves and their children during years of substance abuse. If risk factors and barriers to long term recovery can be addressed while the woman is in a safe place, she will be more likely to have the proper coping mechanisms in place when these issues arise again after leaving the recovery home.

All of society will eventually be affected by considering the issues that are specific to women seeking treatment for substance abuse. The first to be affected by a comprehensive, integrated program that includes treatment for depression and addiction, would be the women

and their children. There has been much written on the lives of children raised by alcoholic parents. These children are typically raised in homes that are chaotic at best, and often include neglect, hunger, physical, emotional, and sexual abuse. Many of the mothers lack parenting skills because of their own upbringing. Many children with their own special needs have those needs neglected due to the mother's inability to access the services her child(ren) need(s). There are women seeking treatment who have not yet had children and to treat all of their issues as well as their alcoholism/drug addiction before they have children could save those future children from the pain of a neglectful childhood and the mother much pain and regret. Supporters of Welfare Reform with an economic focus and a view of the long-term could consider the benefits of targeting or funneling monies into the implementation of recovery programs which address specifically, women's depression, and the underlying issues contributing to that depression. Eventually many more women in recovery would be better equipped with the emotional stability necessary to seek and maintain employment and/or attend college. This will positively effect women's self-esteem as they become self-sufficient and realize that they are capable of accomplishment. This

in turn affects their children, as the children of these women learn about the value of self-determination, self-worth, work, and education through the modeling of their parent figure.

It is important to view and understand this problem with an eye on the long-term results of implementing programs with a myriad of services. The more women are able to take control of their lives and become independent, the more stability there will be in the lives of their children, and the better equipped the women will be to make relationship decisions later on.

The findings of a study focusing on the outcomes of women in a recovery program that includes in its curriculum treatment for depression and specific needs of women, opens an avenue for funding targeting agencies and community based programs interested in providing integrated services to women in their communities. Some questions for research that could have long-term affects on the lives of recovering women and children include: What is the leading cause of depression in women in residential treatment? Is there a difference in the level of depression in women that have their children with them in treatment, women whose children live elsewhere, and women who have no children? Are there a significant number

of women in these treatment facilities who have been victims of sexual abuse and/or domestic violence that warrants the incorporation of treatment for these issues into the treatment program? Does loneliness measured by lack of family and confidante support contribute to high levels of depression?

Problem Focus

It was thought that in order to provide long-term effective treatment for women with alcohol/drug problems, that depression and its contribution to women's substance abuse must be recognized and addressed in treatment programs.

The focus of this research was the gathering of evidence to determine whether residential treatment facilities should include in their core treatment a component in which the woman would be assessed by a professional for depression and evaluated for treatment for that depression if necessary. It is important for social workers and other helping professionals to understand and consider the problems women face when seeking treatment for a history of substance abuse. It was thought that a majority of women in treatment for substance abuse would be found to be depressed and that

treatment for that depression while these women are in a safe and structured environment will greatly increase their chances for long-term sobriety. Three questions were addressed by this study: To what degree are women in residential treatment facilities for substance abuse depressed? What are the social, economic, and environmental issues contributing to this depression? Are these issues, if left unaddressed, barriers to long-term sobriety?

CHAPTER TWO

LITERATURE REVIEW

"Until the 1970s, alcoholism and drug addiction were viewed almost exclusively as problems of men" (McNeece & DiNitto, 1998, p.418). Historically alcoholic and drug abusing women were thought of as deviant, promiscuous, and unfeminine. McDonough and Russell report that, "a congressional mandate in the mid-1980s required increased attention to the growing problem of female alcoholism, but women still accounted for only a very small proportion of research participants in treatment outcome studies." Wilmore and Volpe (1981) suggested the necessity of recognizing the "intricacies and subtleties of women's alcohol problems" to provide successful treatment (p. 1). McDonough and Russell (1994) state that in 1982, Doshan and Bursch reported that "women who abuse substances" should be considered a unique population with treatment plans designed especially for them based on their special needs and problems. In reviewing separate works comparing the topics of loneliness, suicide, sexual abuse, childcare, and support systems to substance abuse, the need for an integrated program that will address

depression and its relationship to each of these issues becomes clear.

Turner looked at alcoholism and depression in women. The major hypotheses of Turner's study were: 1) A substantial number of women alcoholics are also depressed. 2) The achievement of abstinence by alcoholic women who are depressed has no effect on their depression. 3) After one year of treatment, there are significant differences between women who are both alcoholic and depressed and those who are alcoholic and not depressed. Those who are depressed will have more problems in other areas of their lives.

Turner (1992) described a study of alcoholic women done by Corrigan (1980) examining the relationship between their alcoholism and their depression. Hypothesis 1, which states that a substantial number of alcoholic women are also depressed, was confirmed. Women who lived alone, perhaps implying loneliness, who rarely considered themselves self-reliant, and who had low self-esteem were significantly more depressed.

Hypothesis two stated that abstinence alone would not account for an improvement in depression, and this hypothesis was supported. "The fact that abstinence alone did not reduce the women's depression suggests that the

women were not suffering from an alcohol-related depression that would improve when they became alcohol free for two weeks or longer" (Turner, 1992).

Turner's third hypothesis was also confirmed. Of the 69 women who were depressed at the initial interview, 26 remained depressed one year later. According to Turner, "The clinical picture of those who remained depressed is that of loneliness, worry, concern about financial and emotional problems, and low self-esteem" (1992).

Rates of entry into treatment, retention, and completion of treatment are significantly lower for female clients than for male clients (Sandmaier, 1992). Addicted women often cite childcare as a major obstacle to participation in treatment. Women are more likely than men to carry primary responsibility for care-taking in the family, and women tend to experience greater apprehension about relinquishing the role of caretaker to enter treatment than do men (Piazza, Vrbka, & Yeager, 1989). Therefore, there is a strong argument for residential recovery homes that are able to accommodate children to live with their mothers during their residential treatment.

Wobbie and Eyler (1997), in their work on women and children in residential treatment, cite the work of Hughes

et al. (1995) whose research indicated that women will stay in the residential treatment setting longer if they are permitted to have their children with them. Wobbie and Eyler refer to the work of Williams and Roberts (1991) when they say that depression scores were elevated for women who terminated treatment prematurely. Beckman (1994) reports that women's concern for their children can hinder their treatment (if adequate child care is not available or treatment program does not include children). For these women it makes sense that a treatment plan which includes a parenting component and liberal provisions for visiting with children may facilitate the likelihood that the women will remain in treatment. Social support is also an important component of successful treatment outcomes for women in recovery.

In a study done by Medora and Woodward (1991) examining the extent of loneliness experienced by subjects undergoing treatment at selected alcoholic rehabilitation centers, significant differences were found between the loneliness scores of men and women. The women were significantly lonelier than the men. It makes sense to take into account the issue of family and social support when considering the topic of loneliness.

McNeece and DeNitto, in their book titled, Chemical Dependency: A Systems Approach, state that, "not only do chemically dependent women receive less support for entering treatment, they are also more likely to encounter opposition to entering treatment from family and friends" (1998, p. 419). Beckman (1994) addresses this very issue when she cites work done by Gomberg (1993) in which Gomberg states that alcoholic women appear to receive less support from their families and friends than do nonalcoholic women. Many of these women used drugs and/or alcohol as a way to cope with the feelings of loneliness related to this lack of family and social support. An effective treatment program would not only address the needs of the resident but the counseling needs of the whole family as well. Working with family members increases the likelihood of family and social support for the woman once she leaves treatment. Unresolved issues, including those involving family members can lead to relapse upon release from residential treatment.

Research suggests that women who drink heavily or are alcoholic are more likely to become victims of the alcohol-related aggression of others, such as rape. Wadsworth and Spampneto (1995) explored the issues surrounding sexual trauma and the treatment of chemically

dependent women. It was their belief that these women were more prone to relapse than chemical dependent women without sexual trauma issues. Wadsworth and Spampneto found in their research a high incidence of sexual trauma among women who seek treatment for substance abuse.

According to Beckman (1994), the rates of sexual abuse and incest as children or adults are significantly higher among women with drinking problems than in the general population. Clients who have experienced sexual trauma appear to be more susceptible to relapse, the return to substance abuse (Kasl, 1989; Rohsenow, Cotbett, & Devine, 1988; as cited in Wadsworth & Spampneto, 1995). The research of Brown (1991) and Rose (1991), also cited by Wadsworth and Spampneto, seems to indicate that symptoms experienced by sexually abused clients leave this population prone to relapse. It is likely that clients who have histories of childhood sexual trauma and have become chemically dependent may fully experience the pain of the trauma for the first time once the substance abuse has ceased. It makes sense that if these issues are left unaddressed, a return to substance use may occur. Unresolved issues can sometimes lead the individual to resort to what she may perceive as a more permanent solution to the pain.

Canetto (1991) examined the relationships between gender roles, suicide attempts, and substance abuse. Canetto tells us that suicide attempts and substance abuse have traditionally been conceived as distinct, unrelated disorders in the United States. Canetto points out that drug-taking behavior itself has often been referred to as a form of suicidal behavior, and likewise, a majority of all suicide attempts involve the use of alcohol and drugs. Canetto cites work done by Weissman (1974) that states that depression is the diagnosis most typically associated with suicide attempts. According to a review by Weissman (1974), females outnumber males in rates of suicide attempts by an average ratio of 2:1. Lex (1994) cites a study done by Gomberg in 1989 which found that almost five times as many alcoholic women as women in the control group acknowledged suicide attempts, which occurred even more frequently among the younger alcoholic women. According to Weissman, the typical suicide attempter is a depressed woman under the age of thirty who has a history of troubled interpersonal relationships. The most frequent method chosen is by an overdose of drugs. There is a distinct relationship emerging between loneliness, depression, suicide and substance abuse.

After reviewing the literature it seems that there is enough evidence from various sources to support the claim that genuine gender differences exist for those in recovery. Substance abuse in women has risk factors and consequences that differ from those of men. An argument must be made for treatment of depression to be addressed concurrently with the issue of substance abuse. The literature names the issues of children, loneliness, and sexual trauma to be prevalent among women seeking recovery from substance abuse. At the core of these issues appears to be an underlying depression.

If drug/alcoholism treatment services are to be developed that truly meet the needs of women, these factors must be acknowledged and understood. The literature seems to support the claim that the most effective treatment program for female alcoholic/drug addicts requires consideration of depression and the factors operating in a woman's life which contributes to that depression. This includes issues regarding children, social and family support (loneliness), and history of abuse and/or sexual trauma.

CHAPTER THREE

METHODS

This research explored the levels of depression among women in residential treatment facilities. It also explored the barriers that substance abusing women experience in recovery such as childcare, transportation, legal and financial issues, loneliness, family and social support, domestic violence, sexual assault, suicidality and how these issues impact the depression levels of these women. Researchers used a self-administered questionnaire survey design (Appendix A). The survey was used to obtain standard demographic information about the population such as age, race, marital status, number and whereabouts of children, and questions regarding previous alcohol use and abuse of both the respondents and the respondent's family of origin, and previous attempts at recovery. In addition, the survey was designed to obtain information about the issues thought to be contributing to the woman's depression thus affecting her chances for a successful recovery. The survey included the Center For Epidemiologic Studies Depressed Mood Scale (CES-D). The CES-D consists of 20 items to assess the intensity of depression in individuals. The CES-D measures current level of

depressive symptomatology, with emphasis on the affective component-depressed mood.

Data Collection and Instruments

The data was collected by means of self-administered questionnaires provided to voluntary participants by the researchers at the treatment facility in which they live. The collection sites included one women and children, and two women-only residential treatment facilities in Riverside and San Bernardino Counties. Questionnaires were given in English only and took approximately 20 minutes to complete. The survey included the Center For Epidemiologic Studies-Depressed Mood Scale (CES-D). The CES-D consists of 20 items to assess the intensity of depression in individuals, and took approximately 20 minutes to complete. The CES-D measures current level of depressive symptomatology, with emphasis on the affective component-depressed mood.

In addition to the CES-D, the participants were given a questionnaire designed by the researchers to measure the presence or absence of social and family support, loneliness, number and whereabouts of children, history of recovery attempts, substance abuse, domestic violence, sexual assault, and other environmental issues. Twenty of

the questions were asked using a Likert scale method of measurement with four possible levels of response. Twenty-two of the questions required a simple yes/no response (nominal). The questionnaire was pre-tested by the researchers' peers to determine the clarity and understandability of the questions asked. Demographic information was gathered including age, relationship status, ethnicity, and SES. Depression was the dependent variable and the effects of the other variables such as, loneliness, parental drug use, and drug of choice on depression, was assessed.

Sampling

The sample was obtained from women living in women-only and women with children drug and alcohol residential treatment facilities. The women ranged in age from 18 to 54. It was hoped that a sample of at least 100 women would be obtained, however there were 64 participants ($n = 64$). One of the three participating programs provided for the women to have their children with them. Information was gathered to determine which environmental issues contributed to higher levels of depression thus creating barriers to recovery.

The residential treatment facilities were chosen from the Rainbow Resource Directory from Riverside and San

Bernardino counties. These treatment facilities included those who allowed children to stay with their mothers and those who did not. All of these facilities were women-only facilities. It was believed by the researchers that women-only treatment facilities would be more conducive to the special needs of women and therefore more apt to participate in the research process. Many facilities were listed with the qualifications needed to complete the study. A written letter was mailed to the facilities introducing the researchers and the project, describing the purpose of the study, and ensuring the anonymity of the subjects. The researchers then telephoned the administrators of those facilities who responded positively to the inquiry to schedule a convenient time for data collection and to answer any questions and discuss concerns. Once a time had been agreed upon for data collection the researchers traveled to the sites to distribute the questionnaires in person to voluntary participants.

Procedures

Once researchers obtained permission from the Institutional Review Board to conduct the study, the data was collected. Data was collected over a period of two

weeks in March 2002. After explaining the purpose of the study and the procedures, the researchers provided a questionnaire, an informed consent letter (Appendix B), and a pen to each voluntary participant. At the conclusion of the collection, participants were given the debriefing form (Appendix C) and allowed to keep the pen. Completed consent forms were number coded and separated from the questionnaires to ensure confidentiality. Data was entered into the Statistical Package for Social Sciences (SPSS) by the researchers as it was gathered. The researchers will keep the questionnaires in a locked cabinet for three years after which time the materials will be destroyed.

All surveys were handed to the participants at the treatment facility at a time of the day that best fit the individual program. The participants were informed of their right to not participate or to quit at any time during the process. The participants were assured that every effort would be made to ensure their privacy. The entire process took approximately 30 minutes including the explanation of the task, and the distribution and collection of materials. The delivery, administration and collection of the surveys from the three treatment facilities occurred within a two-week period of time in March 2002.

Protection of Human Subjects

The confidentiality and anonymity of the study participants was a primary concern of the researchers and all efforts were made to accomplish this. For the sake of protecting the participants' anonymity and inputting the data, a numbering system was utilized. No participant names were used. Study participants were asked to sign informed consents before they participated in the study and they were informed that they could discontinue at any time during the study. The participants were given debriefing statements with the names and telephone numbers of the researcher and the advisor if they had any questions concerning the study. The participants were also provided with the number to a confidential 24-hour crisis hotline.

CHAPTER FOUR

DATA ANALYSIS

Data analysis included descriptive and inferential statistics. Descriptive analysis included univariate statistics such as frequency distribution, measures of central tendencies, and dispersion to describe various demographic variables. Bivariate statistics such as chi-square were used to examine the relationship between two variables. Pearson's correlational coefficients were used to examine the relationship between demographic variables such as age, number of children, income, relationship status, and the CES-D scale. Independent Samples T-Tests were used to examine the relationships between individual levels of depression and each independent variable representing environmental factors such as transportation, family and social support, legal problems, issues related to children, income, domestic abuse, and sexual assault.

Sixty-six women voluntarily participated in the study and completed the survey. Two did not properly complete the CES-D. Subsequently those two surveys were excluded from the project ($n = 64$). The racial distribution of the women surveyed was: 32 (50%) Caucasian, 12 (18.8%) African

American, 11 (17.2%) Hispanic, 5 (7.8%) Native American, and 2 (3.1%) Other. There were 2 (3.1%) missing. Age was an open-ended question which was placed into categories by the researchers. The highest percentage of respondents were within the 30-39 (46.9%) age group, followed by 18-29 (32.8%) age group. Seventeen point two percent were between the ages of 40-49, and one respondent (1.6%) between the ages of 50-59.

Educational history of respondents was assessed with one (1.6%) respondent reporting having earned a bachelor's degree. 20 (31.3%) reported less than a high school education, 21 (32.8%), a high school education, and 20 (31.3%) reported some college.

Financial resources and employment histories were examined. Source of income in the past year included the following choices and responses from participants; 18 (28%) employment, 3 (5%) Supplemental Security Income (SSI), 9 (14%) Temporary Assistance for Needy Families (TANF) welfare benefits, 1 (1.6%) disability, unemployment benefits (0), or 1 (1.6%) Other, which was open-ended. Open-ended responses included 7 (11%) drug sales, 3 (5%) prostitution, 1 (1.6%) illegal acts, 4 (6%) dependent on a significant other or other family member. Three women reported having been in prison in the past

year, and six women reported "none." Some women reported combinations, for example, 1 (1.6%) boosting (shoplifting) and TANF, 1 (1.6%) SSI and disability, and 1 (1.6%) reported prison and prostitution.

The researchers collapsed variables creating two additional categories from this data. One collapsed category was comprised of four variables: employment, benefits, dependent on family, and illegal. Women who had been in prison were placed in the illegal category since the commission of an illegal act was the cause of their imprisonment. The results read as follows: 18 (28.1%) had been employed, 15 (23.4%) relied on some form of benefit, 4 (6.3%) were dependent on others for support, and 15 (23.4%) had committed illegal acts to support themselves, and possibly their children in the past year. Nine (14.1%) of the women indicated that they had no income.

The second category of collapsed variables included those who had reported illegal acts to support themselves and those who were employed, assuming that there may be a difference in depression level between those women who were self-sufficient and those who were dependent on others for support. By combining these two categories researchers found that 33 (51.6%) of the women were self-sufficient and 16 (48.4%) of them were dependent. In

an Independent Samples T-Test the 33 women who were self-sufficient had a mean score on the depression scale of 39.7576 compared to a score of 48.5625 for the 16 women who were dependent on an outside source for their income. The women who were self-sufficient were significantly less depressed ($p = .001$) than those who were dependent.

Respondents reported that 23 (35.9%) of them were single, 15 (23.4%) of them were in a committed relationship, 12 (18.8%) were married, 6 (9.4%) separated, and 8 (12.5%) reported themselves to be divorced. A total of 27 (42.2%) of the women were in a relationship while 37 (57.8%) were not. Only about half (47%) reported that their partner had a substance abuse problem and 77% of those with a significant other reported that their partner was supportive of their recovery efforts.

Transportation accessibility was assessed for the purpose of identifying additional barriers or obstacles for treatment. Over half, 67.2%(43) of the participants reported that they did not own a car.

Many of the women reported having been victims of abuse at some time in their lives. Forty-seven (73.4%) reported having been victims of physical violence, 55 (86%) reported experiencing verbal and/or emotional violence, and 40 (62.5%) reported having been sexually

abused. Of these three questions, only the sexual violence response category had 1 (1.6%) missing response.

Forty-six (73.4%) of the women reported that they had minor children. Of the women who reported they had minor children, 24 (39%) had three or more children and 22 (34.4%) had one or two children. Forty-three (67.2%) of these children were not with their mothers. Of the children who were not with their mothers, 33 (51.6%) of them were residing with either friends or family, and 13(20.3%) were in foster care. Only 7 (11%) reported that they did not have childcare available to them which would have enabled them to participate in Alcoholics or Narcotics Anonymous meetings after leaving the recovery home.

Twenty-seven (42.2%) of the women were court-ordered into treatment. Interestingly, the women who were court-ordered into treatment were significantly less depressed than those who were not. Using a crosstabulation between the variable "court-ordered" and the depression scale cut at midpoint, 20-49 and 50-80, a Chi-Square result demonstrated that those who were court ordered were significantly more depressed at the $p < .05$ level than those who were not court ordered. Possibly it was a relief for some of the women to have been forced out of a

substance influenced lifestyle. Twenty-eight (44%) of the women reported this to be their first time in a recovery home. Of those who had previous attempts at recovery 16 (25%) reported not having completed the previous program. An open-ended question allowed the women to explain why they had not completed the previous programs. Three of the women had been in programs which allowed for them to have their children with them. One woman stated that she left because another resident's child was hurting her child. Another reported that her child kept getting sick from the other children and that caring for her child was interfering with her ability to fully participate in the recovery program. A third left because of financial disputes related to her children. One woman left to return to her child. The most frequent response to this question was to "get high." Five of six of these women reported heroin to be their drug of choice. The three participating recovery homes did not allow a medical model detoxification in which the women could have received medications to alleviate the painful heroin withdrawal process.

Forty (62.5%) of the women reported that they had grown up in homes where substance abuse was a part of everyday life. Twenty-six (40.6%) reported having

initiated the use of substances between the ages of 6-12. Fifty-six (88.1%) were using by the time they were eighteen-years-old. Although a single response was desired when asked for drug of choice, many of the women listed two drugs as their drug(s) of choice. The researchers then created a category for each drug and entered "yes" if the respondent mentioned that drug and "no" if she had not. Thirty-seven (57.8%) the women reported methamphetamine to be one of their drugs of choice. This was followed by alcohol 27 (42.2%), cocaine 15 (23.4%), marijuana 12 (18.8%), heroin 11 (17.2%), and prescription drugs 6 (9.4%). One (1.6%) woman noted gambling, and one (1.6%) reported men.

Twenty-four (37.5%) of the women reported having received mental health counseling in the past. Twenty-eight reported having previously been prescribed medication for depression and/or anxiety (43.8%). Twenty-two reported thoughts of suicide at times in their past and 23 (36%) reported that they had attempted suicide.

The researchers created a depression scale by calculating the lowest and highest number possible to score on the CES-D. When the variable was divided into three levels and labeled mild, moderate, and severe, only

two women scored within the severe range. The researchers then collapsed the scale by dividing the depression scale in half thus developing a midpoint. The variable DEPSCALE was used to determine differences in level of depression between variables. The two categories were then classified as none to mild and moderate to severe levels of depression.

The researchers hypothesized that having minor children would have a negative effect on the women's level of depression. To assess the relationship between having children and level of depression a crosstabulation was performed. The Chi-Square result was significant at ($p = .042$) level. Of the 59 women surveyed, 44 of them answered "yes" that they had minor children. Of those 44 women, the mean score on the depression scale was 43.7273 compared with 37.8667 for those women without minor children. The researchers then conducted an Independent Samples T-Test between the depression variable and having minor children. The result was ($p = .020$). Again, if a woman had minor children, she scored significantly more depressed than those who did not.

Further tests were conducted to compare the whereabouts of the children to levels of depression. The question was asked, "If your children are not with you,

where are they?" Respondents were given the choice of, other parent, grandparents, foster care, or an open-ended option of "other." In the "other" category were such responses as "one is with me, others have been adopted," "split between grandparents and other parent," "with family," "with aunt" and "with friends." Researchers recoded the variable placing responses into two categories. One included other parent, grandparent, friends, and family. This category was called "non-system." The other category included those who indicated that their child or children were in the foster-care system or as the researchers defined it: out of parental control. It was discovered that "where the children are" was not significant, but having children was a significant factor in predicting depression for recovering women. Women with minor children were more apt to be depressed than those women who did not have parenting issues to contend with.

The variable depression was then assessed with other variables to determine which, if any, of the issues asked about contributed significantly to higher levels of depression.

Each category of "drug of choice" was run against the depression variable, but no drug was found to contribute to higher levels of depression than any other.

The researchers discovered a pattern of depression when measuring the childhood environment. An Independent Samples T-Test was run to determine whether or not the participants' childhood home life contributed to present levels of depression in these women. The question read "Did you grow up in an environment in which substance abuse was an everyday part of life?" Thirty-six (61.2%) women answered "yes" to this question. This was significant at $p = .024$. The mean depression score for those who answered "yes" was 44.2222 as opposed to 39.1304 for those who answered "no." Thus, if the woman answered "yes" she was exposed as a child to an environment laden with substance abuse then she was more likely to have a higher level of depression than those who did not experience this type of environment growing up. Another question asked, "Did either one of your parents have a substance abuse problem?" Forty-two (70%) of the women answered "yes" to this question. An Independent Samples T-Test was performed for this variable and its influence on levels of depression. Findings revealed that if respondent's parents had a substance abuse problem, she

was more likely to be depressed than if neither parent had abused substances. The probability measurement was $p = .006$. A third question related to childhood and early socialization read "Was any part of your childhood spent in Foster Care?" The ten women who answered "yes" to this question scored much more depressed than those who answered "no." This was significant at the level of $p = .006$. The mean depression score for those who spent time in foster care was 48.9000 compared with 40.8776 for those who had not been exposed as a child to foster care.

Loneliness and lack of support were also found to be significant predictors of depression among recovering women. When asked if they considered themselves lonely people 22 (37.5) of the women who answered "yes" scored significantly more depressed than those who answered in the negative. This was found to be statistically significant at $p = .005$. Although 22 (37.5%) women in the sample considered themselves to be lonely, only 7 (11%) answered "no" when asked, "Do you have someone, a close friend or family member outside this program that you can confide in?" These 7 women were found to be much more depressed than those who has a confidante outside of the program ($p = .001$). The mean depression scale score was

51.8571 for those without support in compared with 40.9423 for those with a confidante.

Another area of significance was found between those who had received counseling at a mental health clinic and those who had not. Twenty-one of the respondents stated that they had received mental health services. An Independent Samples T-Test found that these women were significantly more depressed than women who had not previously received services at a mental health facility $p = .024$. It appears that the early initiation of mental health services is an indicator for higher levels of depression among recovering women.

The respondents were also asked their age at first use of any drug. The responses ranged from 6-48 years of age. Data was placed into five categories: 6-12, 13-15, 16-18, 20-25, and 35-48 years of age. Twenty-six of the participants stated that they had first used between the ages of 6 and 12. Eighteen had first used between 13 and 15, and 13 between 16 and 18. A total of 56 women used for the first time by the age of eighteen. In a crosstabulation of "age at first use" and "growing-up in a substance abuse environment," 81% of those respondents who had grown up in an environment in which substance abuse was a part of everyday life, used their first substance

between the ages of 6 and 12. More than two-thirds (65%) of those who began using substances by age 15, grew up in an environment of substance use. There was a strong correlation between childhood home environment and age at first use. Pearson Chi-Square was statistically significant at $p = .014$.

Finally bivariate analysis was performed to assess whether there was a correlation between "age at first use" and levels of depression. The average "age at first use" was 16.2 years, with the average depression of 42.2. Findings indicated statistically significant relationship between these two variables ($p = .008$), verifying that the younger the participant was when she first began using substances, the greater her level of depression was at the time of this study. The findings also gravitate toward a trend between childhood environment and recovering women's levels of depression, with negative childhood environments influencing a rise in adult levels of depression for this population.

CHAPTER FIVE

DISCUSSION

The researchers began this project desiring the participation of both Women Only and Women and Children recovery homes. It was believed by the researchers that women without their children would be significantly more depressed than those women with their children. However, the recovery home allowing children that agreed to participate, only had two women who currently had their children with them. However, what proved to be of interest were the responses given by women who had previously been in treatment programs, and had left the programs early. An open-ended question asked participants why they had left treatment early. Three of the women's responses were related to problems having the children with them. Four questions were postulated to assess challenges for women in recovery and the influences of these challenges on their individual levels of depression. First, what were the leading cause of depression in women in residential treatment? This was found to be family of origin and childhood issues as well as being the mother of minor children. Secondly, was there a difference in the level of depression in women who had their children with them in

The ideal program would be a medical model program in which medications could be introduced to ease the pain and discomfort of heroin withdrawal. A psychiatrist on staff would evaluate the women for depression at periodic intervals during their stay for possible anti-depressant medications. A professional social worker would be employed to address such issues as Depression and/or Post Traumatic Stress Disorder (PTSD). PTSD is seen often as a result of past abuse, as well as abandonment, a feeling associated with a childhood spent in foster care, or guilt and shame associated with not caring properly for their own children. These services in combination with the social-model recovery home's emphasis on 12-step programs (Alcoholics and Narcotics Anonymous) would be more likely to prepare a woman for a successful return to the community. Add to this program a component in which children could live with their mothers but have their own parallel program of recovery and the children could have their needs met, as well with a greater chance for a substance free successful adolescence and adulthood. It makes sense that the recovery home that accommodates children, would benefit from parallel treatment programs for the children. This routine would be similar to one in which mom goes to work, child goes to school, and they

come together for the evening hours to do homework, eat, and bathe. This study proved that these children were at high risk to grow up and repeat the behaviors of their parents.

For programs unable to provide on-site accommodations for the children, an out-patient type program in which the children were educated about addiction and its role in their separation from their mothers, would be an asset to the family when they are reunited. Perhaps one or two days a week the children could visit the facility for individual therapy, family therapy, and a fun interaction of some kind with their mother.

After-care services for both the women and their children are advisable as well. Turner's research indicated that one-third of his population remained depressed even after a year of abstinence reinforces the idea of after-care. Childhood and abuse issues are long-standing and cannot be resolved during a 60-90 day residential treatment stay. Likewise, the children have been harmed emotionally and need to do their own work. A mother and her children reunited after ninety days with the only change being sobriety, continue to conduct their daily lives in a dysfunctional way. There is much to be learned by them both for the long-term healing process.

Limitations

1. The researchers had hoped to have a larger sample size. Time and travel constraints prevented the researchers from soliciting participation from recovery homes beyond the local geographical area. 2. The researchers had also hoped to reach more women who had their children in treatment with them. 3. Personal interviews with some of the women may have shed more light on personal issues and childhood experiences affecting the women today.

Recommendations for Social Work Practice, Policy and Research

Future Research

Some residential programs do offer after-care services. An implication for future research might be more longitudinal in nature measuring levels of depression at entry, exit, and after 6-12 months of aftercare.

A more focused study might examine the abuse issues reported by so many of the women in this study. This research makes it clear that violence contributed to the women using substances as an escape from emotional pain.

Another issue made clear by this study was the issue of harm being done to the children of these substance

abusing women. A study done to ascertain the needs of these children and the services required to meet those needs is called for.

Policy

Many states are beginning to recognize the impact of addiction in the judicial system. California recently enacted Proposition 36, which provides for first time non-violent drug offenders to receive treatment in lieu of jail. This is a powerful first step. When treatment programs can also be implemented for the children of these addicts, the family as a unit can begin the long recovery process.

Also, more substance abuse treatment is needed in the prisons for both men and women. Women released from prison hoping to reclaim their children must be prepared to care for children scarred by the actions of their parents. Substance abuse has become the primary coping mechanism of these women and the stress of re-entry into society makes relapse into substance abuse a likely occurrence without a foundation of recovery.

Implications for Social Work

Social workers working with these women must realize the importance of Systems Theory and the need to treat the entire system and not just one of it's parts. The women in this study revealed that the homes that many of them came from lacked the influences necessary to prepare them to provide a healthy functional home to their children. To stop the cycle, both the needs of the women and the children must be addressed. The use of a timeline, a genogram, or an eco-map, concrete and visual, would be instrumental in helping these mothers to asses the familial patterns of dysfunction that are at work in their lives and the lives of their children.

CHAPTER SIX

CONCLUSION

The majority of women seeking treatment in residential treatment facilities for substance abuse have children who are not currently with them. Sixty-three percent of these women grew up in a home in which substance abuse was a part of everyday life. Seventy percent of them reported parental substance abuse. Nearly two-thirds of them have been a victim of sexual violence, nearly three-fourths of them physical violence, and eighty-six percent of them report to have been victims of verbal/emotional violence! These women are preparing at the least, the third generation of addicts, alcoholics, victims, and perpetrators.

It is clear from this study that substance abusing women face many other hardships as well in their desire to change their futures. There is a proven need for programs employing professional staff who can address the deep-rooted issues these women bring with them into recovery. The children of these mothers are in need of professional child therapists who are versed in proven ways of helping children to acknowledge and accept feelings brought about by perceived abandonment and

neglect. A staff psychiatrist is recommended to evaluate the women for depression and/or anxiety and the possible need for medications for these conditions. Aftercare services are indicated to provide a continuum of support following release from residential treatment and the reunification of the family.

In closing, it has been proven that the problems faced by recovering women today are the results of their formative years and past experiences. Likewise, the children of these women are at risk to repeat the behaviors of their mothers if programs are not created to address the needs of both.

APPENDIX A
QUESTIONNAIRE

QUESTIONNAIRE

1. How old are you? _____
2. What is your ethnicity or race?
 1. Caucasian
 2. Hispanic/Latino/Chicano
 3. Asian/Pacific Islander
 4. African American
 5. Native American/American Indian
 6. Other _____
3. What is your highest grade completed? Circle One.
 1. Less than high school
 2. High School Graduate
 3. Some College
 4. AA or AS Degree
 5. Bachelor's Degree
 6. Graduate Degree
4. What has been your primary source of income for the past year? Circle One.
 1. Employment
 2. TANF
 3. SSI
 4. Disability
 5. Other (Please Specify) _____
5. Do you own a car or have a car available to you?
 1. Yes
 2. No
6. If not, what is your primary source of transportation? Circle One.
 1. Walk
 2. Bus
 3. Taxi
 4. Friend or family member
 5. Other (Please Specify) _____

7. What is your marital status? Circle One.
1. Single
 2. In a committed relationship
 3. Married
 4. Separated
 5. Widowed
 6. Divorced
8. Does your spouse or significant other have addiction/chemical dependency problems?
1. Yes
 2. No
9. Have you been, as a child, or adult, a victim of physical violence?
1. Yes
 2. No
10. Have you been, as a child, or adult, a victim of verbal and/or emotional abuse?
1. Yes
 2. No
11. Have you been, as a child, or adult, a victim of sexual abuse/violence?
1. Yes
 2. No
12. If in a relationship, is your partner supportive of your choice to be in this residential treatment program?
1. Yes
 2. No
13. Did you grow up in an environment in which substance abuse was an everyday part of life?
1. Yes
 2. No

14. Was any part of your childhood spent in foster care?
1. Yes
 2. No
15. Do you have any minor children?
1. Yes
 2. No
16. If yes, how many minor children do you have? _____
17. If yes, are they with you in residential treatment?
1. Yes
 2. No
18. If your children are not with you, are they:
1. In Foster care
 2. With another parent
 3. With a grandparent
 4. Grown
 5. Other _____
19. After you graduate from this program, do you have someone to watch your children while you attend AA or NA meetings?
1. Yes
 2. No
20. Do you have someone, a close friend or family member outside this program that you can confide in?
1. Yes
 2. No
21. If yes, how often do you talk to this person either on the telephone or in person?
1. Daily
 2. Three times a week
 3. Once a week
 4. Twice a month
 5. Once a month
 6. Less than once a month

22. Are you court-ordered to be in this program?
1. Yes
 2. No
23. Is this your first time in residential treatment?
1. Yes
 2. No
24. If no, how many times have you been in residential treatment before?
- Enter a number _____
25. If this is not your first time in residential treatment, was your child or children living with you in that program?
1. Yes
 2. No
26. If yes, did you get after-care support for any of the following issues?
Please circle all that apply.
1. Transportation
 2. Child care
 3. Financial
27. Did you complete the program or programs?
1. Yes
 2. No
28. If not, why did you leave early? Briefly explain
-
29. Either in previous facilities or at the present time, if one had been available to you, would you have preferred a residential treatment facility where you could have your children with you?
1. Yes
 2. No

30. Did either one of your parents have a substance abuse problem?
1. Yes
 2. No
31. What is your drug of choice?
1. Alcohol
 2. Methamphetamine
 3. Cocaine
 4. Heroin
 5. Prescription Drugs
 6. Inhalants
 7. Marijuana
 8. Other _____
32. What was your age at first use of any drug? _____
33. Have you ever received counseling at a mental health clinic?
1. Yes
 2. No
34. Have you ever been prescribed medication for Depression or Anxiety?
1. Yes
 2. No
35. Would you consider yourself a lonely person?
1. Yes
 2. No
36. Do you ever think about suicide?
1. Yes
 2. No
37. Have you ever attempted to commit suicide?
1. Yes
 2. No

Using the scale below, please indicate the number which best describes how often you felt or behaved this way – DURING THE PAST WEEK.

1 = Rarely or none of the time (less than 1 day)

2 = Some or a little of the time (1-2 days)

3 = Occasionally or a moderate amount of time (3-4 days)

4 = Most or all of the time (5-7 days)

During the past week:

- 38. _____ I was bothered by things that usually don't bother me.
- 39. _____ I did not feel like eating; my appetite was poor.
- 40. _____ I felt that I could not shake off the blues even with help from my family or friends.
- 41. _____ I felt that I was just as good as other people.
- 42. _____ I had trouble keeping my mind on what I was doing.
- 43. _____ I felt depressed.
- 44. _____ I felt that everything I did was an effort.
- 45. _____ I felt hopeful about the future.
- 46. _____ I thought my life had been a failure.
- 47. _____ I felt fearful.
- 48. _____ My sleep was restless.
- 49. _____ I was happy.
- 50. _____ I talked less than usual.
- 51. _____ I felt lonely
- 52. _____ People were unfriendly
- 53. _____ I enjoyed life.
- 54. _____ I had crying spells.
- 55. _____ I felt sad.
- 56. _____ I felt that people disliked me.
- 57. _____ I could not get "going."

Thank you for your time and participation in this study.

APPENDIX B
INFORMED CONSENT

INFORMED CONSENT

Our names are Angel Garcia and Coralyn McCabe and we are MSW students at California State University, San Bernardino. We would like to invite you to participate in our study that investigates the obstacles and issues faced by women in recovery, it is hoped that the results will expand the knowledge base for those social workers that work with substance abusing women. You will receive a pen to use in filling out the questionnaire that is yours to keep whether you complete the study or not. The Department of Social Work Sub-Committee of the Institutional Review Board at California State University, San Bernardino, has approved this study.

If you choose to participate in this study, you will be asked to complete the enclosed questionnaire. This should take about 20 minutes of your time. The questions asked will concern your life experiences, previous attempts at recovery as well as questions pertaining to your psychological well-being.

Your decision to participate in this study is entirely voluntary. If you decline or withdraw from the study, you are free to do so without any negative consequences. This study entails no foreseen risks.

Your responses will remain completely confidential and your identity will not be revealed at any time during this study. If you choose to participate, please complete the attached questionnaire and sign the informed consent letter with an X. Bring the letter and the questionnaire forward when you are finished.

Please feel free to contact us, Coralyn McCabe, at (909) 658-1827, Angel Garcia, at (909) 864-4023, or our research advisor, Rachel Estrada LCSW at (909) 736-6660, if you have any questions or concerns regarding this study. If you have any questions about your rights as a participant in this study, you may call California State University, San Bernardino, at (909) 880-5000 and ask for the Department of Social Work.

Thank you for considering participation in this study. If you agree to participate please indicate with an X and fill in the date below.

By placing an X on the blank below, I acknowledge that I have been informed of, and that I understand, the nature and purpose of this study. I freely choose to participate. I also acknowledge that I am at least 18 years of age.

_____ (Please mark this space with an X) Date: _____

APPENDIX C
DEBRIEFING STATEMENT

Debriefing Statement

The questionnaire you have just completed was designed to examine the issues and obstacles faced by the substance abusing woman seeking recovery and her psychological well being. In this study two ideas were assessed: That women have issues other than substance abuse which effect her psychological well-being and need to be addressed in residential treatment facilities. The questions were designed to elicit the responses necessary to draw conclusions about these ideas.

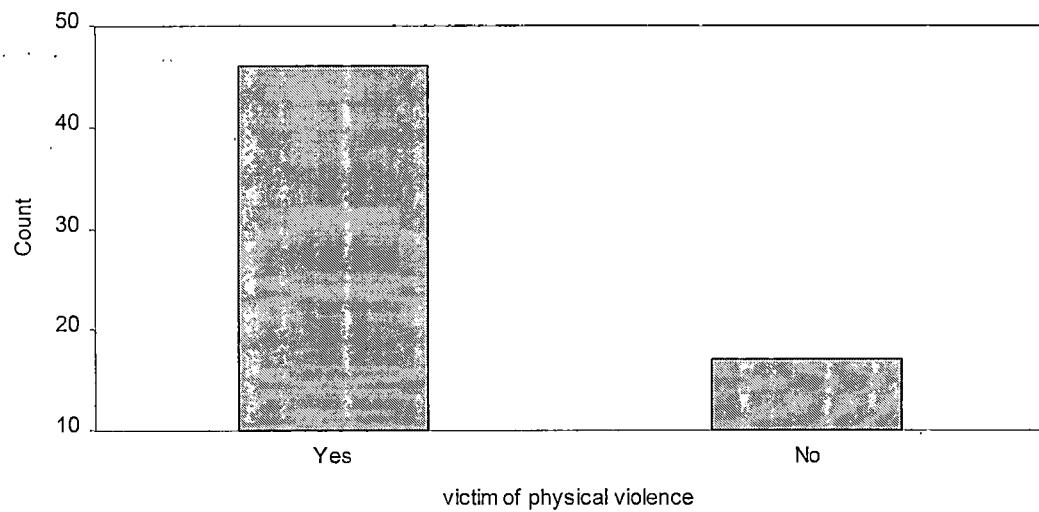
Thank you for your participation. If you have any questions about this study, please feel free to contact Coralyn McCabe at (909) 658-1827, Angel Garcia at (909) 864-4023 or Rachel Estrada LCSW at (909) 736-6660. The results of this study will be available in the Pfau Library and in the Department of Social Work at California State University, San Bernardino beginning July 2001.

If this study has surfaced up any personal issues that you feel need further discussion please consult with your counselor and/or sponsor. The following phone number may also be helpful (800) 321-2843, for information or confidential assistance 24-hours a day.

APPENDIX D

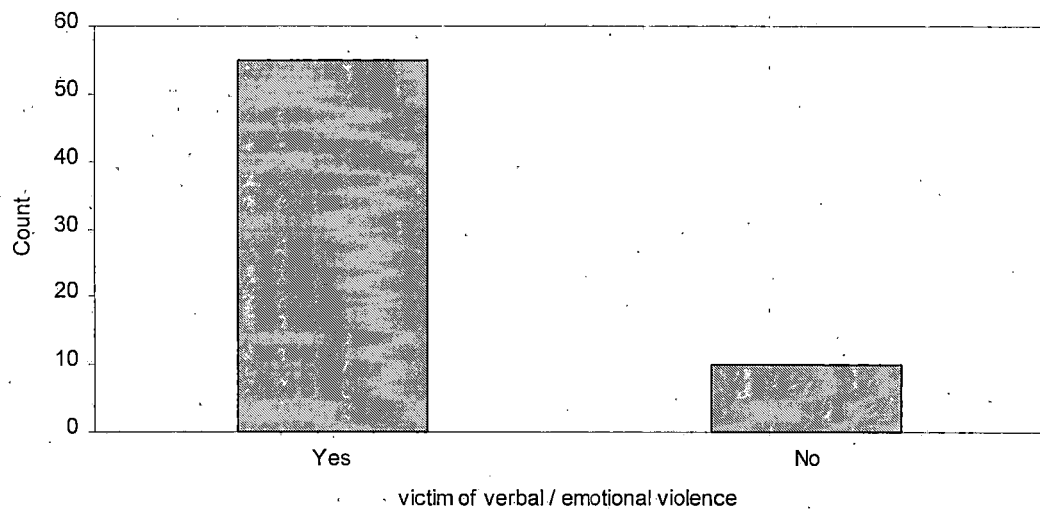
THE NUMBER OF RESPONDENTS WHO
WERE VICTIMS OF PHYSICAL,
VERBAL/EMOTIONAL, AND SEXUAL
VIOLENCE

CASES OF PHYSICAL VIOLENCE



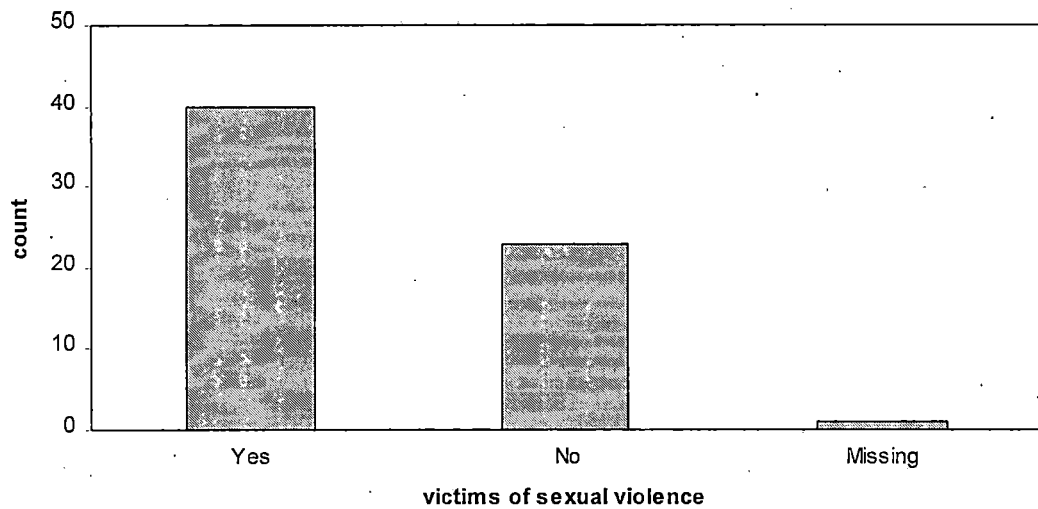
This bar chart represents the number of women who reported having been victims of physical violence.

CASES OF VERBAL / EMOTIONAL VIOLENCE



This bar graph represents the number of women who reported having been victims of verbal/emotional violence.

CASES OF SEXUAL VIOLENCE



This bar graph represents the number of women reported having been the victims of sexual violence.

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ASSIGNED RESPONSIBILITIES PAGE

This was a two-person project where authors collaborated throughout. However, for each phase of the project, certain authors took primary responsibility. These responsibilities were assigned in the manner listed below.

1. Data Collection:

Assigned Leader: Angel Garcia

Assisted By: Coralyn McCabe

2. Data Entry and Analysis:

Team Effort: Angel Garcia &
Coralyn McCabe

3. Writing Report and Presentation of Findings:

- a. Introduction and Literature

Team Effort: Angel Garcia &
Coralyn McCabe

- b. Methods

Team Effort: Angel Garcia &
Coralyn McCabe

- c. Results

Team Effort: Angel Garcia &
Coralyn McCabe

- d. Discussion

Team Effort: Angel Garcia &
Coralyn McCabe