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What Is “Women-Focused” Treatment for Substance Use Disorders?

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Abstract

Over the past three decades research has highlighted gender differences in substance use disorders and substance abuse treatment participation. Programs devoted to addressing women's treatment needs, broadly encompassed in the term “women-focused treatment,” have multiplied. This column examines the rationale for women-focused treatment and describes some of its components. The authors cite the need to evaluate women-focused treatment by developing validated measures of the processes embodied in such treatment and by conducting empirically sound research on clinical outcomes, treatment effectiveness, cost-effectiveness, and the optimal means of providing services to women with substance use disorder.

Substance abuse treatment before the 1970s followed a generic approach in which there was little recognition of the specific treatment needs of women and men. Spurred by the women's movement in the 1970s, which illuminated pervasive gender inequalities in social life, significant differences between men and women with regard to substance use and addiction were increasingly recognized. They include gender differences in the initiation of substance use, progression to dependence, and social influences that facilitate or impede treatment participation. In response, separate women-only programs were developed as well as dedicated treatment “tracks” or services for women within mixed-gender programs.

By the 1980s public attention on the cocaine epidemic often fixated on pregnant or parenting women, with lurid media depictions of crack use among mothers. At the same time, several national demonstration projects were implemented in which treatment programs and services were developed specifically for pregnant and parenting women, leading to an increase in the number of women in treatment, particularly in women-only treatment facilities (1).

Subsequently, a body of research documenting the effectiveness of these emergent approaches for treating women with substance use problems and their families was developed. The 1994 National Institutes of Health Guidelines on the Inclusion of Women and Minorities as Subjects in Clinical Research (2) further emphasized the need to examine gender differences and treatment outcomes for women with substance use disorders (3). Since the 1990s there has been an increase nationwide in programs for women that are focused on comprehensively addressing their treatment needs. These programs and treatment approaches have been variously referred to as “single-gender,” “women-focused,” “women-sensitive,” “women-

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specific,” “gender-sensitive,” or “gender-responsive.” In this column we use “women-focused” or “single-gender” treatment to encompass all of these terms.

The evolution of these various constructs stems from conceptual and empirical evidence demonstrating the importance of addressing gender differences and needs in the treatment process (4). In particular, these treatment approaches have been informed by research demonstrating the high prevalence and significant impact on treatment of other psychiatric disorders, such as mood, anxiety, and eating disorders, among women who have substance use disorders; the high prevalence of trauma exposure among women with substance use disorders and their associated physical and mental health needs; and the central role that relationships with children, intimate partners, and others play in women's addiction and recovery.

Rationale for women-focused treatment

Several rationales for women-focused treatments have been presented. They include individual patient preferences for treatment programs or services for women that are provided by women; greater ability to focus on gender-specific content; an environment and treatment process that allow enhanced comfort and support, which may be especially important for women who have a history of trauma; and an opportunity to provide adjunctive services that are key to successful treatment outcomes among women (4,5).

It is not clear from research what proportion of women with substance use disorders would prefer single-gender over mixed-gender programs or whether treatment in gender-specific programs should always be recommended for women. However, women are less likely than men to obtain any treatment for substance use disorders over the lifespan (4). The stigma attached to substance use among women, which melds negative images of women's sexuality and their fitness as mothers, accompanied by social and familial ostracism, is often cited as a reason that women do not seek treatment. Moreover, when substance use is embedded in intimate-partner relationships, women may jeopardize their relationships if they seek treatment. It is possible that increased access to women-focused substance abuse treatment might enhance treatment-seeking among some women. Preferences may also be strongly influenced by other characteristics, such as age, race-ethnicity, culture or religion, sexual orientation, a history of trauma, and psychiatric sequelae. In addition, women's preferences for treatment are likely to be influenced by their access to social support and resources, especially from their families and communities.

Single-gender treatment also provides an opportunity to focus on gender-specific content within the treatment process, including caretaking roles, intimate-partner relationships, exposure to trauma, reasons for relapse, and co-occurring psychiatric disorders (4). Some studies have reported that single-gender treatment provides a safer and more comfortable treatment environment, which may enhance treatment outcomes, and that women experience greater satisfaction with such treatment than with a mixed-gender alternative (5).

Ample empirical support has been found for the importance of providing “matched” or “tailored” services that address the specific needs of women in treatment, including parenting and family-related services, mental health and general medical services, comprehensive case management, and employment and economic supports (6). Moreover, strong evidence has been found that programs that are either dedicated to women's treatment or in which a majority of the clients in treatment are women are more likely to provide these services (7).

Components of care that can be women focused

The proliferation of single-gender programs in the 1990s and 2000s has enabled the development of a rich body of research on the characteristics of these treatment programs. This

research has typically examined a range of organizational characteristics, including the types of services provided and the frequency of their delivery; the composition, ownership, revenue sources, and client referral sources of the treatment facility; and the characteristics and training of the program director and staff. Yet there are many dimensions of the organization and delivery of treatment that can be informed by a women-focused approach. They include the treatment intervention (for example, individual or group treatment that is manual based and replicable), level of care or treatment modality (inpatient, partial hospital, residential, intensive outpatient, and outpatient), and treatment system (treatment program plus adjunctive services, such as child welfare, housing, education, and job training) (8).

Evaluation of women-focused treatment services

Research is needed to assess the degree to which treatment programs are women focused by evaluating these services in several domains, including gender composition, the focus of treatment content, and the availability of comprehensive and adjunctive services with a demonstrated relationship to women's treatment outcomes. Gender composition of treatment services can be assessed in terms of whether programs provide services only to women or embed women's services within mixed-gender settings, as well as in terms of the gender distribution of program staff and clinicians. Women-focused content of treatment programs can be evaluated with respect to whether it focuses on antecedents and consequences, as well as risks for relapse and specific relapse prevention strategies that may have greater relevance or effectiveness for women than for men. Finally, programs can assess the degree to which they provide access to comprehensive and adjunctive treatment services that bolster positive treatment outcomes for women, including child care and parenting, general medical care, housing, job training and employment, and mental health care for co-occurring disorders.

Implications for development, implementation, and evaluation

Research on the effectiveness of women-focused treatment paradigms requires the development of appropriate methodologies and instrumentation. The field currently lacks adequate measurements of the therapeutic and programmatic components of women-focused treatment, which are essential to empirical validation of its effectiveness and dissemination of effective treatment approaches. The development of instruments to measure women-focused treatment services and interventions that encompass the three domains described above would be a valuable contribution to the field.

In addition, women with substance use disorders are a heterogeneous population with respect to socioeconomic circumstances, cultural background, substances of abuse, family and parenting status, and co-occurring disorders. It is therefore critical to evaluate the effectiveness of women-focused treatments in various service settings with subgroups of women who reflect the diversity of this population. As women-focused treatments are delivered to diverse populations, the need to evaluate the moderators and mediators of treatment outcome, including such characteristics as severity of substance use, co-occurring psychiatric disorders, social networks and relationships, and employment and educational attainment, becomes even more critical.

Finally, within our rapidly changing health and social services system, delivery of substance abuse treatment is increasingly embedded within other systems rather than in stand-alone specialty programs. Women are often screened for substance use disorders and referred to substance abuse treatment by other service providers, including those in primary care, urgent care (such as for victims of violence), welfare agencies, the criminal justice system, child welfare and protective services, and mental health programs. The organization of service delivery and the implications of providing women-focused treatment in different service

settings are not well understood, and further research is critical for successful cross-system delivery of treatment to women.

Conclusions

The current diversity in the nomenclature that refers to substance abuse treatment dedicated to meeting women's needs reflects the richness in treatment approaches that are being developed and applied in practice. The diversity in approaches is exciting and also reflects a maturation of the field, which has progressed from an initial focus on gender differences in addiction to a deeper understanding of how gender informs the progression of substance use and addiction, treatment utilization, and recovery. However, for fuller maturation, in which research can advance practice as well as policy initiatives dedicated to improving the provision of substance abuse treatment to women, it will be critical to develop validated measures of constructs and to conduct empirically sound research on clinical outcomes and treatment effectiveness, as well as on cost-effectiveness and optimal organization of service delivery.

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