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# FOUR KEY CHARACTERISTICS OF CHEMICALLY DEPENDENT WOMEN

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## Introduction

Chemically dependent women must cope with their addictions while concomitantly combating stigmatism and blame as a consequence of their chemical dependency and being prone to certain health problems resulting from their addictions. The purpose of this article is to identify several key characteristics of women who abuse drugs: a) ethnicity, b) gender differences, c) patterns of female chemical dependence, and d) socioeconomic status.

Punitive measures have often been taken against women who abuse drugs, and they are increasingly being prosecuted for drug use or drug-related behaviors (Singer, Bussey, Song & Lunghofer, 1995; Teen Challenge World Wide Network, Substance Abuse Letter, 1995). Efforts to force women into treatment are sometimes accompanied by threats of incarceration or loss of custody of their children (National Center on Addiction and Substance Abuse (CASA) at Columbia University, 1996). In this article the terms “chemical abuse” and “dependency” will be used interchangeably (Babor, 1992). These terms refer to women whose use of alcohol or drugs results in clinically significant impairment of their ability to live normal lives (i.e., to perform home, work or school tasks, activities of daily living, and may include physiological withdrawal, tolerance and a compulsive pattern of drug use) (APA, 1994).

## Ethnicity

According to Kandall (1998) and Stimmel (1996), racial bias is an important factor in determining which groups are more likely to be prosecuted for use of illegal substances. Goldberg (1995) contended that although rigorous studies in different parts of the country demonstrated no significant differences in drug abuse identified at the time of delivering babies among different racial and economic groups, women of color were 10 times more likely to be tested than White women (Chasnoff, Landress, & Barrett, 1990; Kandall, 1998), and subsequent child protection interventions were implemented far more often for women of color (Maher, 1992). Among women, alcohol and drug use are most prevalent during the childbearing years (Stein & Cyr, 1997). Annis (1990) reported that client characteristics contribute to predicting responses to alcohol and drug-treatment programming. Prognostic characteristics such as being married, financially secure, employed, of a high social class, socially active,

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well-adjusted to work and marriage, having few or no psychiatric problems and having no history of arrest tended to correlate with positive responses to alcohol and drug treatment. The converse is also true; chemically dependent individuals with poor prognostic characteristics do not respond as well to treatment.

Though it is often assumed that illicit drug use is associated with a higher occurrence of chemical dependence among minority populations who more frequently reside in urban cities, national surveys contradict this claim (Stimmel, 1996; Tollett, 1990). While there is an association between a reduction in income and an increase in illicit drug use, substantial drug use can be found in suburban and rural areas. Stimmel (1996) contended that it is income level rather than ethnicity that seems to define substance use. Goldberg (1995) reported that a larger proportion of White Americans consume more legal and illegal drugs when compared to other racial or ethnic groups. Native Americans provide the exception due to excessive alcohol use. Stimmel (1996) further suggested that ethnicity should not be considered as a causative factor in explaining the use of legal or illegal drugs or inability to reduce their use in specific communities. Considering ethnicity as a causative factor in drug use can be divisive and nonproductive, creating a barrier that can hinder an effective search for solutions to drug dependence proclivities.

Sanders-Phillips (1998) asserted that African American women seem to have a greater affinity for using over-the-counter medications, cocaine, marijuana, PCP (phencyclidine), and heroin than other groups. In contrast, Latino women of Mexican-American origin had the lowest rates of use of illicit drugs while Mexican immigrant women showed slightly greater tendency to use illicit drugs than their aforementioned counterparts.

DeLaRosa, Khalsa, and Rouse (1990) indicated that the rates of drug use among female Hispanic subgroups is influenced by the degree of acculturation in this population. For example, they contended that Mexican-Americans and Puerto Ricans born in the United States and speaking English as their primary language seemed most vulnerable to the use of illicit drugs. It was further suggested that greater drug use by these groups may be associated with inadequate schooling, poverty, limited opportunities for employment, and racial discrimination. Sanders-Phillips (1998) also maintained that the greatest differences in male-female substance use behavior is demonstrated by Latinos in comparison with other cultural or ethnic groups and suggested that this difference may be related to cultural differences in expectations associated with women's roles in the Latino community. This is a community that strongly opposes chemical dependency in women and employment outside of the home, leaving Latino women largely dependent upon their addicted partners or entitlement programs. According to CASA (1996), while White women are more likely than African American or Hispanic women to engage in illicit drug use, the rates of addiction to

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drugs are similar for these three groups. African American women tend to converge at the extremes of either abstaining or becoming regular users.

### **Gender**

Drug abuse research and treatment traditionally have focused on men, with less attention to ethnicity, gender differences, female patterns of chemical dependency and socioeconomic status. This is true even though women and men differ notably in their patterns of abuse and addiction, psychology, physiology, and risk factors (CASA, 1996). A report by the nonprofit Michigan Women's Foundation (1995) revealed that although women comprise 30% of treatment admissions for drug use, they account for 58% of drug users in the United States. An increase in the number of women seeking treatment has been noted in research on substance abuse among women. O'Connor, Berry, Inaba, Weiss, and Morrison (1994) observed that in a one-year period (between 1988-1989), outpatient and residential treatment programs in San Francisco reported between 30% and 40% of their admissions were women. Similarly, Engs (1990) observed that national surveys found that 24% of alcoholic and 33% of drug-dependent treatment admissions, respectively, were women.

According to the National Institute on Drug Abuse (NIDA) (1994) over 5 million women in the United States used drugs; this figure may be as high as 6 million women using illicit drugs (Jessup, 1997). Jessup (1997) indicated that 14% of women who use illicit drugs have tried cocaine and 44% have tried marijuana, and that women ingest 80% of all amphetamines and 60% of all antidepressants prescribed in the United States. Blumenthal (1998) reported that in one year alone more than 1.2 million women had taken prescription drugs for non-medical reasons, and in one month 3.6 million women had used marijuana. More than two-thirds of the AIDS cases occurring among women were drug-related (Blumenthal, 1998; NIDA, 1994; Stein & Cyr, 1997).

### **Patterns of Female Chemical Dependence**

Lex (1994) compiled data from experimental, clinical, and survey findings to describe the consequences of alcohol and other drug abuse by women. Accordingly, some patterns of female chemical dependency identified by this investigator were:

1. Women tend to be younger than men when they begin using alcohol and other drugs, and when they first enter treatment.
2. Women in alcoholism and other drug abuse treatments more frequently list social reasons for their substance abuse than men.

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3. The primary reason given by chemically dependent women for engaging in drug abuse is that their male partners are using drugs.
  4. Typically more women in treatment are also depressed or suffer from anxiety disorders, whereas more men tend to have anti-social personality disorder (p.214).

According to the National Household Survey on Drug Abuse (NIDA, 1997), men (8.5%) have a higher rate of current illicit drug use than women (4.5%). Men (0.9%) were more likely to use cocaine than women (0.5%). Stein and Cyr (1997) reported marijuana was the illicit drug most commonly used by women, with 10% of women under 35 years of age reporting they used marijuana. Substance abuse among women in high school, included in a 10-year longitudinal research study, demonstrated a linear relationship between increased marijuana use and the use of other illicit drugs (Stein & Cyr, 1997). Poverty and poor education are also commonplace for a number of these women, especially women of color, as well as those who are HIV-infected and low-income (Goldberg, 1995; Quinn, 1993).

Chemically dependent women tend to identify the onset of their drug use as sudden and heavy, generally commencing after experiencing a specific traumatic event in their lives (Nelson-Zlupko, Kauffman & Dore, 1995). It has also been suggested that a family history of drug abuse was one of the most cogent risk factors for development of dependency in individuals (Goldberg, 1995; Guthrie, Boyd, & Hughes, 1997; Merikangas, 1998). In addition, findings of Hser, Anglin and Power (1990) were supported by research by CASA (1996), which revealed that female cocaine and heroin users appeared to develop dependency to substances much sooner than their male counterparts.

The characteristics shared by chemically dependent women need to be understood because “their patterns and consequences of alcohol and other drug abuse appear to be influenced by factors that differ from those of men” (Lex, 1994, p. 212). Women’s substance abuse problems tend to be telescoped when compared with men, and the health of women may be more seriously affected by chemical dependence than men (CASA, 1998; Goldberg, 1995; Stein & Cyr, 1997). Even though it is commonly believed that more men enter and complete treatment for addiction than women, a higher proportion of women seek treatment for illicit drug abuse than men, although a greater proportion of men tend to abuse alcohol and other drugs in comparison to women (Goldberg, 1995; Manhal-Buagus, 1998; Merikangas, 1998). According to Moras (1998), in cases where treatment-seeking differs by gender, experts suggest several basic reasons for this difference such as socioeconomic and racial background, shame, fear of loss of children, and societal expectations for responsible parenting.

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## **Polysubstance Abuse**

Polysubstance abuse is a common occurrence among individuals abusing drugs. Most women in treatment for alcoholism and drug abuse have also been found to abuse one or more additional substances (Lex, 1994; Masbaum, 1997; Nelson-Zlupko et al., 1995). Beck, Wright, Newman, and Liese (1993) estimated that between 20% to 30% of alcoholics in the general population and approximately 80% in treatment programs are dependent on at least one other drug. According to these researchers, a common combination is marijuana, alcohol, and cocaine. Further, Miller and Rollnick (1991) contended that such multiple drug use occurs for a number of reasons. For example, some drugs, such as alcohol, are used to decrease the effects of other drugs (i.e., anxiety and tremors induced by a cocaine high). Conversely, cocaine may be used to escape unwanted side effects caused by use of alcohol (i.e., depressant effects of low to moderate quantities of alcohol are alleviated by use of cocaine).

Although women's drug use typically involves legal drugs (alcohol and prescription medication), Jessup (1997) asserted that approximately 40% of incarcerated women disclosed daily use of illicit drugs a month prior to being imprisoned. In addition, substance abuse and chemical dependence increasingly are becoming problematic for elderly women. These women are more likely than men or women in the general population to keep their substance abuse and chemical dependence secret (Davis, 1997; Hirata, Almeida, Funari, & Klein, 1997). A 1998 report released by Columbia University (CASA, 1998) reported that 17% of Americans over age 60 suffer from alcohol abuse or abuse/addiction from prescription medications. Currently the elderly comprise 12% of the United States population. This group consumes approximately 30% of all prescription drugs and more of all medications (prescription and over-the-counter) than any other group (King, Hasselt, Segal, & Hersen, 1994). In comparison to men, alcoholism tends to become a problem later in the lives of women, perhaps due to role deprivation resulting from divorce or separation (CASA, 1996). Moreover, women over 55 years of age have a declining tolerance for alcohol, making them more prone to addiction. There is an indication that elderly women who abuse alcohol are less likely to seek treatment and are more inclined than men to use prescribed psychoactive drugs (CASA, 1996).

## **Socioeconomic Status**

Poverty and poor education are commonplace for a number of chemically dependent women, especially women of color, as well as those who are HIV-infected and low-income (Goldberg, 1995; Quinn, 1993). According to CASA (1996), women with higher incomes are more likely to experiment with illicit drugs than low-income women. However, regular drug use is more common among impoverished women. This report noted that nearly 50% of women earning minimum incomes of \$75,000

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per year have used illicit drugs. Heavy drinking rates appear to decline with higher levels of education (CASA, 1996). Women who have some college education, but have not completed a degree, have substantially higher levels of binge drinking than those with either a bachelor's or graduate degree.

Restricted job opportunities related to sex-role conflicts and other marginal influences may affect female Latino addicts more than other ethnic and cultural groups (Anglin, Hser, & Booth, 1987). Consequently, in comparison with White female narcotic users, Latino female narcotic users are more likely to come from low-income households, receive welfare or disability payments, and be unemployed (Sanders-Phillips, 1998).

Women working outside of the home, especially in male-dominated occupations, and those who are recently unemployed seem to be at increased risk for alcohol abuse when compared to homemakers (CASA, 1996). In comparison to male addicts, chemically dependent women have less education, fewer marketable skills resulting from limited work experience, and decreased financial resources. Most chemically dependent women are currently unemployed and have not been employed within the previous year, causing them to be dependent on family or entitlement programs for survival (Michigan Women's Foundation, 1995; Nelson-Zlupko et al., 1995). According to the Michigan Women's Foundation report (1995), approximately 50% of women receiving treatment for substance abuse in Michigan were unemployed.

### **Conclusions**

Chemical dependence in women is often an ineffective consequence of their efforts to cope with oppressive conditions in their lives. Accordingly, women have traditionally demonstrated significantly lower rates of treatment, retention, and treatment completion in comparison with male clients. Chemical dependency is a disease that contributes to oppression of women in many ways – economically, socially, and psychologically.

A necessary prerequisite to more equitably address the needs of this population requires making the effort to understand women who abuse drugs. Individual practitioners and other health care professionals require education about chemically dependent women to reduce and minimize prejudices and preconceived notions about this population. Such notions often result in harsher treatment and less tolerance than male addicts experience (Goldberg, 1995). Accurate knowledge of the characteristics of chemically dependent women can also facilitate development of effective prevention and treatment planning. This knowledge can also motivate health care providers to act as advocates for female substance abusers and reduce pessimism regarding treatment outcomes. By understanding underlying factors contributing to chemi-

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cal dependence in women, increased quality of interventions can be developed within the health care system. New paradigms in chemical dependence for women that focus on their uniqueness can positively impact the lives of their children and help them become productive women who are able to eliminate their dependence on drugs.

Improving services in the treatment of chemically dependent women and prevention can be best achieved by paying special attention to individual biases and attitudes toward women who abuse drugs. Research has found that addicted women have low self-esteem and tend to experience considerable anxiety, shame, and guilt about their addictions (Jessup, 1997; O'Connor et al., 1994). Consequently, professionals need to be sensitive to the social disdain, greater stigma, and painful humiliation that many chemically dependent women experience upon seeking treatment. The professional relationship established with clients forms the basis for working with them to effect beneficial changes in the direction of increased health and productivity. According to Curtin (1996), the foundation of the professional relationship is the mutual humanity of its participants and "sensitivity to the client's humanity helps professionals look beneath the surface for the human response to actual or potential health problems" (p. 66). If human vulnerability is considered by health care professionals, their ability to respond in a more reasonable, caring, and understanding manner can be enhanced.

Effective treatment must go beyond traditional strategies and should include an unbiased knowledge of chemically dependent women's concerns and issues. The high failure treatment rate among women is likely due in part to the fact that many current treatment programs fail to address specific problems and concerns of women. Most existing programs were designed for male clients with an aggressive, confrontational, punitive focus developed to break through denial, and are generally ineffective when used with women (Nelson-Zlupko et al., 1995). New forms of treatment are needed that recognize the uniqueness of women in society and the disproportionate amount of trauma that they experience as a result of their dependency. The focus needs to be on identifying, increasing, and reinforcing their strengths, while creating an emotionally safe, supportive environment that allows each woman in treatment to address issues at her own rate and intensity.

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