Consideration of Gender Specific Factors in the Development of Adolescent Alcohol and Other Drug Interventions and Treatment

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Abstract

Reasons for increased rates of addiction and substance involvement among adolescent girls are examined in light of the absence of gender parity in service planning and delivery. Pathways and risk factors to addiction unique to girls and young women are outlined along with their implications for the development of effective interventions. An analysis of our failure to reach girls while rates of substance abuse decline in boys is undertaken, and the importance of program planning that addresses major issues for girls is stressed. Essential components for the treatment of adolescent girls in both single sex and coed programs are explained. Recommendations for measures that will assure parity in the planning of services within New Hampshire are included.

The Anatomy of Our Failure is Female

Alcohol and other drug addictions are increasing in adolescent girls at an alarming rate. Current intervention and treatment systems have been developed primarily to address addiction in men and boys, as females in need of services have historically constituted a minority. Extreme stigma, socially constructed ascriptions of gender, and numerous other barriers have contributed to the exclusion of women and girls from research and program design in alcohol and other drug addiction treatment systems. Evidence suggests that the shortcomings of the system in regard to the unique needs of women and girls have resulted in a death rate from alcoholism that is now 50-100 percent higher in females (Sullivan, Fama, Rosenbloom& Pfefferbaum, 2002) and a situation that designates girls as the most at risk individuals and the most likely to place others at risk (Alexander, 1997; OJJDP, 1996).

Intervention efforts aimed at male populations such as employee assistance programs and impaired driver interventions fail to take into account the situation of women. Prevention and treatment efforts aimed at youth are generally tailored to the needs of boys and young men who are stereotypically considered likely to act out by experimentation with alcohol and other drugs, while girls are not.

The reality of addiction and abuse, however, increasingly stands in sharp contrast to socially constructed gender stereotypes. In the 2001 Youth Risk Behavior survey 80% of New Hampshire high school girls reported having at least one drink of alcohol, and 53% reported drinking in the last 30 days. Thirty-eight percent of females in a University of New Hampshire Teen Assessment Program reported binge drinking in the last month; binge drinking is defined as having 5 or more drinks in a row (2002). Many experts now

agree that levels of consumption for men and boys need to be adjusted for women and girls. Metabolic differences mediated by weight, body fat, stomach enzymes, hormonal levels and other physiological factors are responsible for higher blood alcohol levels for longer periods in women and girls consuming identical amounts to their male counterparts (CASA, 2003; Hill, Muka, Steinhauer & Locke, 1995; Sullivan Fama, Rosenbloom& Pfefferbaum, 2002; van der Walde, Urgenson, Weltz & Hanna, 2002; Wilsnack & Wilsnack, 1994).

In Canada smoking rates of women have surpassed those of men, despite increased regulation and targeted public health efforts. While overall smoking rates are declining, young women's smoking is surpassing that of young men. These data indicate a radical revamping of prevention policies is in order--a gender specific analysis that does not seek to ignore the relationship between chemical dependency in women and girls, the social reality of women's dependent status, and the status of their dependent children (Alexander, 1997).

In fact an astute analysis of epidemiological trends reveals that the current equality of use and abuse rates of adolescent boys and girls is due to addiction and use in girls *continuing to rise* while it has declined in boys. " Persisting high rates of substance use and the closing of the gender gap demonstrate that teenage girls are not getting the message" (CASA, 2003, p iii).

The number of women entering the criminal justice system is on the rise. More of these women than their male counterparts are addicted to alcohol and drugs. Two-week prevalence rates for substance abuse disorders of incarcerated women were significantly higher than males (GAINS, 2002). Women arrestees are more likely than men to test

positive for illicit substances (Inciardi, Lockwood & Pottieger, 1993). Since the enactment of the 1986 mandatory drug-sentencing laws, the rate of increase for incarcerated female drug offenders has surpassed the rate of males. In 1995 the number of women in state prisons for drug offenses increased by 95% as opposed to 55% for men (Covington, 2001). From 1986-1995 the rate of women incarcerated for drug offenses increased 888%, with 35.9% currently serving time for possession only (Covington, 1996, 2001). Yet, treatment services for women within the criminal justice system remain woefully inadequate.

Within the juvenile justice system the disparity of services is even more pronounced. Facilities offer few options for girls, and programs that house girls who are pregnant or postpartum are almost non-existent (OJJDP, 1996). In New Hampshire, treatment beds in the juvenile justice system are only available for boys (Minard, Merrow, Stapleton & Gagnon, 2002). Yet, from 1992 to 1996 arrests of juvenile females committing Violent Crime Indexed offenses increased 25% while they remained stable for boys. Property Crime Indexed offenses increased 21% among girls while declining 4% among boys (Budnick & Shields-Fletcher, 1998). It is important to note that assault charges among girls nearly always stem from familial disputes and disputes with friends or acquaintances and rarely from stranger violence (OJJDP, 1996). The majority of girls are detained for status crimes, and running away is the sole offense where females surpass males (Budnick & Shields-Fletcher, 1998; OJJDP, 1996, Prescott, 1998). One researcher asserts that "among juvenile girls identified as delinquent by court, over 75% have been sexually abused and in attempting to mitigate that abuse by running away, they are often labeled as delinquent" (Calhoun as quoted by Prescott, 1998, p3-4).

Intervention systems have yet to be instituted effectively within child protective services, a major point of entry into the social service system for addicted women and girls. It is nationally recognized that current child protective system poloicies actively discourage women with alcoholism and other addictive illnesses from seeking help (Liebschutz et al; 2001, CWLA, 2003). The fear of losing child custody is a major deterrent in accessing recovery services (NHTFWA, 2003). These problematic policies are under study by national institutes such as the Child Welfare League and the Children's Defense Fund (CWLA, 2003; CDF, 2003). It is estimated that up to 78% of foster placements are due to parental addictive illness (Young & Gardner, 2002), and that children of addicted mothers who have had a history of out of home placements have an extremely high likelihood of also becoming addicted (Clark, 2001). They are also at risk for incarceration, violent victimization and sexual victimization. These girls grow into teens, and "teenage girls are likelier than women of any other age to smoke, binge drink and use illicit drugs during pregnancy" (CASA, 2003, p v) and often lose custody of their own children. Yet, human service systems have wasted multiple opportunities to intervene in this situation.

Rates of interfamilial violence, rape, and childhood sexual and physical abuse among girls seeking treatment for alcoholism and other drug addiction are astoundingly high. Addicted women reporting one or more forms of physical and sexual abuse across studies range from 75-89% and higher (Clark, 2001; Liebscultz et al, 2002; Price & Simmel, 2002). Up to 70% of drug using girls report having been sexually abused before the age of sixteen, and more that 80% had at least one addicted parent (NIDA, 1994). Current data from a new Harvard School of Public Health survey states that 1 out

of 5 women will have experienced interpersonal violence within a dating relationship before the age of sixteen (Silverman, Raj, Mucci & Hathaway, 2001).

The Crucial Positioning of Intervention with Girls

The collective result of these factors is a system that is largely unresponsive to the needs of females. Women rarely enter into treatment until late stage addiction is upon them and their mental and physical health has deteriorated, along with their financial situation and their family life. Alcohol is the third leading cause of death among women 35-55 (Alexander, 1996). The potential to intervene at a much earlier stage with women and girls exists. However, it will require very specific planning. It will require thought and the inclusion of research specific to girls in the development of prevention, intervention and treatment programs.

Nowhere is that specificity more needed than with the population of adolescent girls. Substance involved girls are particularly in need of programs that address the development of a healthy gender identity. Their very entry into the conflicted roles young women face exerts a set of developmental challenges that are unique and inextricably linked with behaviors that will put them at risk for addictive illness. The specific needs of girls can no longer be ignored in adolescent treatment programs. Girls' pathways in and out of addiction stand in sharp contrast to those of boys.

By designing programs crafted to address the issues of young women and girls, we can prevent a perpetuation of disturbing trends in the increase of addiction and its consequences among this population. The pressures that face adolescent girls are very different from those facing adolescent boys, and the risk factors differ substantially. At

no time in history has this developmental juncture been more difficult for girls (Pipher, 1994).

Designing early interventions is especially critical since evidence suggests girls move from experimentation with substances into problematic use and addiction more quickly than boys (CASA, 2003). Additionally, adolescent girls have significantly higher rates of binge drinking and illicit drug use while pregnant than their adult counterparts, and substance use during pregnancy is related to a family history of drinking among female relatives and past illicit drug use (CASA, 2003; Handmaker, Miller & Manicke, 1999). Yet, tragically, no programs exist in this state designed specifically to treat this high risk, easily identifiable population, despite the potential to redeem two lives for the price of one. The sole women's program in the state, Odyssey Family Center, accepts pregnant and parenting women, but rarely admits girls under the age of 18. The facility is not set up to treat younger, addicted, pregnant teens that may need to finish high school, or may be more appropriately treated within their communities.

Major Issues and Risk Factors for Girls:

- Girls and women tend to use and drink in order to hold on to intimate relationships. For adolescent girls a dating partner is often the gateway to drinking behavior, while the same is almost never true for boys.
- Interpersonal violence, rape and date rape, sexual coercion, and issues of childhood sexual abuse and trauma are major risk factors for developing addictive illnesses in girls.

- Body image, eating disorders, and weight and appetite control are significant motivators for girls to begin to experiment with substances such as tobacco, amphetamines, cocaine, alcohol and opiates, as well as other drugs with anorectic properties.
- Socially constructed gender roles and media images of femininity present girls with the task of developing an identity that is paradoxical in nature. The demand to be sexual at a younger and younger age, coupled with earlier onset of puberty is presenting children with choices that are difficult for grown women. "Puberty—especially early puberty—increase[s] the risk for substance abuse among girls more than among boys" (CASA, 2003, p 1).
- New evidence suggests that girls respond more strongly than boys to peer pressure, that they are introduced to substance use at an earlier age than boys, and that their physical and cognitive development is more severely affected (CASA, 2003).
- Women and girls tend to begin using substances to relieve stress. Stress among adolescent and pre-adolescent girls is a prevalent complaint, and stress relief is cited as a significant contributor to relapse. Males tend to relapse due to overconfidence (Hodgins, el Guebaly & Addington, 2001; Price & Simmel, 2002; Pursley-Crotteau, 2001).
- Rates of mood disorders are higher in women and girls, and adolescent girls who experience depression have a high likelihood of developing addictive illness. The University of New Hampshire Teen Assessment Program found 84% of females

surveyed report depressed feelings in the past month; 26-29% reported serious thoughts of suicide and 18 % reported attempting suicide (2002).

Hence adolescent treatment programs can increase their effectiveness for girls by addressing these and other issues in gender specific groups and programs. A fundamental difference in the overarching philosophy that predicates the development of successful early intervention with girls is related to these issues and risk factors. Boys tend to exhibit behavior with antisocial features when developing pathologies that sometimes accompany substance involvement and addiction (van der Walde, Urgenson, Weltz & Hanna, 2002). Thus social norm theories that underpin prevention programs with adolescent boys may be effective. Girls, however, may need to question, or at least think critically about conformity to social norms in order to mitigate their risk of substance involvement. The societal messages about women and girls place them at risk for developing eating disorders and for engaging in earlier and earlier sexual behaviors. It is **as crucial** for girls at risk for substance abuse to critique cultural norms as it is for boys to conform to them. This fundamental difference cannot be adequately addressed in mixed programs.

Research on group norms and gender suggests that females tend to hang back in groups where males are present and display a significant reluctance to disclose, especially about issues related to sexual abuse, incest and rape. Conversely, males tend to benefit from the presence of females and display a wider range of emotion (Covington, 1996, 1998, 2001;Hodgins, el Guebaly & Addington, 2001; Price & Simmel, 2002; Pursley-Crotteau, 2001).

Girls are more susceptible to peer pressure and partner pressure. They are more relational in their orientation and show stronger susceptibility to the influence of partner and familial use (CASA, 2003; Glover-Reed& Leavitt, 1998; Price & Simmel, 2002). On the positive side, spiritual, religious and moral training and involvement exert a strong influence on girls and appear to be more prophylactic than for boys (CASA, 2003). Research also suggests that females are more open to seeking help for their addictive disorders but are more likely to do so in a mental health setting. Some data point to better responses among females to behavioral, cognitive and educational approaches, and to outpatient and lower intensity programs (Hodgins, el Guebaly & Addington, 2001; Pursley-Crotteau, 2001). The strongest predictor of a girl's success in treatment is her counselor's expectation that she will succeed (OJJDP, 1996). These examples illustrate that programs addressing the realities and risk factors for young women that build on their strengths may promise successful outcomes.

In light of these data, what are the implications for policy and programs aimed at adolescents in New Hampshire? The attitude that it takes a healthy nerve to demand resources be spent on girls when there are not enough programs for boys must be abandoned. In New Hampshire rates of spending on programs for adolescents, for women, and for pregnant and post partum females are well below national averages (New Futures, 2002). What happens when all three intersect? The state of New Hampshire owes its girls, its women and its children parity in prevention and treatment of addictive illness.

"Programming as if Girls Mattered" (Chesney-Lind, 1998, p 31)

The remainder of this report will outline some recommendations that will assist in the development of alternative treatment models that account for needs of adolescent girls by the implementation of gender specific interventions and treatment. The two alternatives are single sex programs and gender specific services within coed programs.

Due to the realities of political and financial constraints I will focus most of my recommendations on gender specific services that can be implemented in coed programs. However, I must stress that single sex programs are preferable. Many girls who come from unsafe homes, or homes where addictive illness abounds, are in need of residential settings. It is also likely there are as many New Hampshire girls who could benefit from single sex outpatient services. Efforts toward the creation and funding of single sex model programs for adolescent girls should be a planning priority. It is crucial that we begin to accrue both demographic and outcome data with this population in order to plan, implement, and evaluate effective programs. Additionally, the very existence of such pilot programs facilitates the creation of collaborative linkages necessary for communities to begin to respond to the needs of girls. Blended funding streams and challenge grants such as those available to the states under the 1992 JJDP Act should be investigated. Gender bias in the delivery of placement and treatment services for girls involved in the Juvenile Justice system is one of the focus areas of these grants (OJJDP, 1996). Programs that screen, intervene, treat and support pregnant and parenting alcohol and other drug-addicted teens are ethically and fiscally essential. The absence of programs dedicated to girls sends a message of disempowerment and hopelessness.

Recommended Elements of Gender Specific Adolescent Programs

Strength Based Approach- Many girls who have survived violent chaotic homes, incest and sexual abuse, and homes with one or more addicted parents and siblings have developed significant survival skills. Self-medicating with alcohol and drugs may have started out as a means to survive. Reframing some maladaptive behaviors as a survival response to trauma and abuse can help girls to let go of shame, thereby clearing the way for the development of self-esteem. By building on qualities such as willingness and resiliency, girls can begin to examine the maladaptations that must be overcome and replace them with positive coping mechanisms. This imparts a sense of agency and control that can facilitate participation in shaping a brighter future. By utilizing participatory models, peer mentoring and soliciting ideas, feedback and suggestions at various junctures, not only can more responsive programs and more inclusive evaluations ensue, but also girls can begin to place some value on their own experience.

Small Single Sex Groups- Girls are in need of a safe place to explore issues and build peer support. Many adolescent girls experience significant isolation, withdrawal, self-hatred, depression and self-mutilation. In small, single sex groups they can begin to discuss sensitive issues of abuse, early sexualization, guilt and shame. The first order of need in all trauma protocols is safety, and many researchers in the field of addictions treatment for women and girls recommend that trauma survival be assumed when designing programs for females (Covington, 1996; Prescott, 1998; CSAT, 1994: CSAT, 2002). Girls need to feel safe from sexual harassment and the threat of victimization. They also need modeling of trusting relations and boundaries by female counselors and

facilitators. Additionally, work on gender specific group normative behaviors and relational therapy models, such as those developed at the Stone Center, suggest all female groups are more likely to maximize participation and retention (Covington. 1996, 1998; Hodgins, el Guebaly & Addington, 2001).

Trauma Informed Services- Beginning at the assessment phase, and extending through all crisis intervention protocols and treatment programming, it is crucial that all staff who come in contact with addicted girls are trauma informed and trained. The eradication of retraumatization throughout the continuum of care should be a priority as the first mandate of all intervention should be *do no harm.* Trauma and abuse screening should be a critical component of the intake process. A trauma theory should underlie the development of therapeutic interventions with adolescent girls, and research should begin in order to select the most appropriate trauma response model for addicted girls. Lisa Najavitas' Seeking Safety model or the ATRIM mode (Addiction Trauma Recovery Integrations Model) are some of the candidates for consideration (SAMHSA, 2001). Awareness of the potential for retraumatization should influence all surveillance, restraint, crisis intervention and disciplinary protocols as well as all exposure to male clients and counselors. **Confrontational approaches effective with boys are not appropriate here.**

Integration of a Strong Female Presence- In addition to the utilization of female counselors and staff, programming for girls should make use of female resources at every juncture. Role modeling by female leaders in the community, especially culturally

appropriate role models that include female community leaders of color and recovering women, can be integrated as a resource for educational groups and mentoring programs. Exposing girls to political, artistic, spiritual, entrepreneurial, vocational and cultural female organizations and activities within their communities results in a broadening of their horizons. Twelve step groups such as Alcoholics Anonymous have Public Information and Hospital and Institutions committees that can provide female speakers. Planned Parenthood of New Hampshire, the New Hampshire Coalition Against Domestic and Sexual Violence, the YWCA, Girls Inc., The New Hampshire Minority Health Coalition, and the New Hampshire Task Force on Women and Addiction are just a few of the resources available. Modeling female independence and agency effectively empowers young women to question limitations imposed by socially constructed stereotypes of femininity.

Extensive Therapeutic and Educational Components that Address Crucial Issues- Girls are in dire need of non-coercive educational type group work that focuses on healthy boundaries, assertiveness training, stress management, spirituality and parenting. Issues of body image--eating disorders and healthy weight and fitness management, women's health, reproductive choice, and prevention of sexually transmitted diseases should also be addressed in single sex psycho-educational groups. Girls are the most at risk for HIV infection. According to The Journal of the American Medical Women's Association (2001) teenage girls' rate of HIV infection from heterosexual sex rose by almost 117% between 1994 and 1998, and females ages 15 to 19 experienced a 90 % increase in the rate of HIV infection due to injection drug use during

the same period. Infection rates among women entering the criminal justice system are as high as 35% (Covington, 1996, 2001). Girls should be engaged in single sex psycho-educational programs where they learn to identify and address high-risk behavior and other key issues. Simply knowing that proper condom use can prevent the spread of HIV is of no use to a girl who is clueless when it comes to setting boundaries in intimate relationships, or is completely lacking in assertiveness skills. They must acquire the full range of knowledge and skills needed to maintain their recovery and build a future for themselves. Family work, affective work and work that strengthens self-esteem and self-efficacy all play a part in ensuring recovery.

Conclusion

There are many more aspects of gender specific treatment and intervention that should be included in program planning. I have provided a rough sketch of some of the key components. But, the suggestions of one lone researcher are a paltry substitute for the allocation of resources and the prioritizing of planning aimed at mitigating the disturbing downward trajectory many of New Hampshire's girls and young women are becoming hopelessly locked into. A system that perpetuates this failure to reach our daughters and sisters will result in more addicted mothers, the birth of more substance affected babies and more deaths of women in the prime of life. At this juncture, New Hampshire must look forward and inward when planning prevention, intervention and treatment efforts with youth, and must designate young women and girls as an underserved population. Resources are needed immediately to correct these inequities and ensure that parity for girls and boys is a major focus of all planning. New Hampshire

has these resources within the community. The quality of life for children and the level of community response to issues that threaten our youth is strong in this state. If these human and community resources are marshaled in a concerted, focused effort to respond to the situation of at risk and addicted girls, it is likely the financial resources can be procured. But, if there is no gender specific planning, there is sure to be no gender specific funding.

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