



Substance Use Disorder and Women:
Physical and Psychological Effects

3 Hours

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Final Exam

1. According to the American Society of Addiction medicine, “addiction is a primary, _____disease of brain reward, motivation, memory and related circuitry.
 - a. Compulsive
 - b. Difficult
 - c. Chronic
 - d. Negative

2. _____, the first professional to examine the cycle of addiction and discuss in terms of phases.
 - a. Dr. Marlatt
 - b. Dr. Oz
 - c. Dr. Jellinek
 - d. Dr. Phil

3. The three phases of Dr. Jellinek are:
 - a. Crucial Phase, Chronic Phase and Detoxification Phase
 - b. Chronic Phase, Disorder Phase and Rehabilitation Phase
 - c. Crucial Phase, Drunken Phase, Recovery Phase
 - d. Crucial Phase, Chronic Phase and Rehabilitation Phase

4. The assessments that are used as screening tools in the Short Brief Intervention for Referral to Treatment (SBIRT) are:
 - a. AUDIT only
 - b. DAST and CRAFFT
 - c. AUDIT, DAST and CRAFFT
 - d. None of the above

5. Assessments that are useful for clinicians to use for women are:
 - a. BDI and ASI
 - b. LOCUS and BDI
 - c. BDI and the DAST
 - d. ASI and LOCUS

6. Addiction Severity Index (ASI) has _____ number of scales?
 - a. 7
 - b. 10
 - c. 9
 - d. 5

7. According to the US Centers for Disease Control and Prevention _____ are prescribed _____ at a higher dose for a longer time.
 - a. Adolescents; SSRI's
 - b. Women; painkillers
 - c. Geriatric ; painkillers
 - d. None of the above

8. According to Moss-King the four components of addiction are:
 - a. Attachment, friendship, daily activities and QOL
 - b. Friendship, attachment, cultural, love of the needle / ritual
 - c. Attachment, Cultural, Rituals / Love of the needle, Lifestyle
 - d. A and B

9. One of the physical effects from a woman taking opioid medications is:
 - a. Nausea
 - b. Inability to concentrate
 - c. Emotionally bound
 - d. Amenorrhea

10. _____ is a form of meditation and has been effective in substance use disorders and effective in recovery.
 - a. CBT
 - b. Mindfulness
 - c. Existential Therapy
 - d. Yoga

11. _____ is a type of psychosis after child birth that has been researched for many years for women that are not in active addiction.
- Depression
 - Schizophrenic
 - Psychosis
 - Post-Partum Depression
12. EMDR was created to discover and to identify _____ feelings that create negative emotions that can lead to anxiety and or depression which can be masked with addiction to control the overwhelming emotions.
- Negative feelings
 - Traumatic
 - Sad
 - Angry
13. The importance of _____ is important for beginning recovery along with proper insurance to receive adequate services.
- Family support
 - Detoxification
 - Housing
 - A vehicle
14. The 4 processes of Motivational Interviewing are:
- Engaging, focusing, evoking and planning
 - Planning, Crying, Loving, Curiosity
 - Engaging, planning, Loving, Understanding
 - Understanding, focusing, evoking and planning
15. The spirit of Motivational Interviewing:
- Acceptance, Togetherness, Understanding and Evocation
 - Acceptance, Compassion, Evocation and Collaboration
 - Compassion, Togetherness , Understanding and Evocation
 - Compassion, Acceptance, Understanding and Evocation

16. According to Miller and Rollnick (2013) change talk is:
- Self – Expressed language
 - Altruistic language
 - Self – Efficacy language
 - None of the above
17. There are four types of parenting styles. Which style is with rigid rules and base the discipline on punishment whether physical or withdrawing love and affection? The results are the children tend to be more conforming to others and are often concerned with pleasing the parent.
- Permissive – Indulgent Parenting
 - Authoritative Parenting
 - Authoritarian Parenting
 - Permissive – Uninvolved Parenting
18. This is a disorder that is rare but a serious condition in which an infant or young child doesn't establish healthy attachments with parents or caregivers.
- Reactive Attachment Disorder
 - Negative Attachment Disorder
 - Lack of Knowledge Disorder
 - None of the above
19. Statistics have shown that women that stay in abusive relationships usually continue with _____.
- Living with the partner
 - Addiction
 - Relapsing
 - Recovery
20. One of the areas that therapist should consider when counseling women with substance use disorders is _____.
- Past or Current traumatic events
 - Strengthen the recovery process
 - Treatment plans
 - Length of time in Recovery

Biographical Summary

Davina Moss-King, Ph.D. CRC, CASAC, NCC

Dr. Moss-King is the president and owner of Positive Direction and Associates, Inc. and has 25 + years of experience counseling individuals with substance use disorders. She graduated from the State university of New York at Buffalo with a Ph.D. in Counselor Education in 2005. As a New York State Credentialed Alcohol and Substance Abuse Counselor and a Certified Rehabilitation Counselor and a National Credentialed Counselor Dr. Moss-King has worked in the Western New York area in all areas of substance abuse treatment. Dr. Moss-King's primary focus for research is women's / children's health along with creating coping mechanisms and lifestyle changes for women using substance that are harmful. Dr. Moss-King has recently published a 1 hour course sponsored by the World Continuing Education Alliance of the United Kingdom (2016). Dr. Moss-King has published the book Unresolved Grief and Loss Issues Related to Heroin Recovery (2009) along with a Continuing Education course regarding women using opioids during pregnancy. She has also published a chapter in the text book Substance Abuse and Treatment (2013). Dr. Moss-King is a member of the American Psychological Association and The National Neonatal Therapist Association.



Course Abstract:

This course is designed for social workers who are working primarily with women diagnosed with substance use disorders. The course reviews how women are affected by substances either physically or psychologically. Physically, the therapist will be working with the biological effects from a medical model. However, there are psychological effects resulting from addiction or leading to addiction. Such psychological effects leading to substance use disorders are domestic violence situations and traumatic life events. Such events resulting from the psychological effects include Reactive Attachment Disorder, and negative effects on the family to name a few. The course also identifies the therapeutic techniques that are the most helpful when working with women diagnosed with substance use disorders. Other areas that are addressed in the course are: pregnancy and substance use disorders, and HIV.

Learning Objectives:

1. Identify the critical complex issues that women experience as a result of substance use.
2. Describe the medical issues that can be pre-disposed prior to addiction.
3. Discuss the long – term impact that childhood trauma and parental styles has on the woman attempting recovery.
4. Identify assessments that counselors can use during post-partum depression and other mental health issues
5. Evaluate the important issues that qualified health professionals need to be aware of for women to progress through the recovery process

Defining Substance Use Disorder

There are new alarming rates regarding women that are diagnosed with a substance use disorder. In the past there has been an overwhelming amount of literature surrounding alcohol and substance use and treatment, however, there is limited literature regarding women as individuals attempting to recover from alcohol and other substance issues. A clinician who is working with a woman in active addiction or in recovery must have a clear understanding regarding the effects of substances on a woman's body as opposed to a man's body and this course will address the differences biologically. This course will also discuss the salient issues that affect women in recovery from addiction such as stress management, post-traumatic stress disorder, post-partum depression, and HIV. The course will provide appropriate strategies through therapeutic techniques to assist the qualified health professional to develop treatment planning strategies to improve the recovery statistics.

The research over the past few years has begun to acknowledge that addiction wears a different mask for women in active addiction compared to men in active addiction. Women have many different themes as to the reasons they suffer from their addiction in silence. Treatment is hindered because of shame, stigma by society, various types of abuse, family issues, lack of treatment facilities and lack of resources in their community (Covington, 2008). As history has shown, women earn salaries just at or below the poverty line and this may limit the women from obtaining health / medical insurance. The lack of health / medical insurance is a hindrance to treatment unless the woman has been fortunate enough to have family support or scholarships available to assist with inpatient or outpatient treatment for the recovery process to begin. There are other barriers to treatment for women which include but may not be limited to

wait lists because of bed unavailability or a lack or limited medical coverage (Fisher, D., Reynolds, G., Hosmer, D et. al, 2017).

The recovery process can begin at five different levels as defined by the American Society of Addiction Medicine (2015) the five levels of treatment are: acute detoxification, opioid maintenance therapy, inpatient rehabilitation, outpatient rehabilitation and residential treatment

Acute Detoxification	Medical management to eliminate opioids or alcohol from the body safely while avoiding intense withdrawal symptoms.
Opioid Maintenance Therapy	Medical managed prescribed replacement therapy with the choices of methadone, buprenorphine (subutex) or suboxone.
Inpatient Rehabilitation	Intensive rehabilitation for 60 – 90 days that include individual therapy, group therapy and an introduction to sober recreational activities. The patient will reside at the inpatient facility.
Outpatient Rehabilitation	Individual therapy and / or group therapy that occurs 2 or more times a week and the patient lives away from the outpatient facility at home or a supervised facility.

Residential Treatment	Facility where the patient will learn independent living skills along with attending outpatient, vocational training or participating in remedial education.
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Vignette 1: Mary Elise is a 35 year old woman that has been using alcohol since the age of 15. Mary Elise has family members that have a history of alcohol use and there are some female family members that are still in active addiction. Mary Elise has often stated that after a long day she enjoys a glass of wine, but lately she states that she has been using the alcohol on a nightly regular basis and she is starting to notice changes in her behavior when she does not have alcohol available. Mary Elise also states that she is finding herself desiring to drink at lunch time because of the stress of her job. Mary Elise also states that she has made an attempt to not drink, but she is beginning to notice that she is sweating and is also very short tempered. Mary Elise also stated that she noticed that these symptoms stopped when she drank. Mary Elise has now decided to talk with her primary physician about these changes. Mary Elise fears that the doctor may prescribe anxiety medication and then she will not be able to drink and this disturbs her; as a result, she has cancelled her appointment. Mary Elise's drinking has become uncontrollable and she has now gone to the emergency room because she has fallen while under the influence. The emergency room physician completed the Short Brief Inventory for Referral to Treatment (SBIRT) and the results indicated she requires medical attention to address the alcohol concerns. Mary Elise is now faced with the decision: What level of care is offered to address the alcohol use disorder? What will happen to her job if she attends a residential program? At this point her employer does not suspect

that there is an addiction problem since she has been able to maintain structure during work hours.

Criteria to diagnose substance use disorders

According to the American Society of Addiction Medicine (2015), “addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry.

Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors” (ASAM, 2015, pg 3).

In other words, men and women that are introduced to a substance can become addicted overtime when he or she continues to use the substance to continuously achieve the same first reward experience. [As mentioned previously The American Society of Addiction Medicine identifies five levels of treatment. All of these treatment levels are accessible to women and men; however, there is empirical evidence that states women have far fewer opportunities to become involved with treatment and actually completing treatment. A woman can be referred to one of these five levels of care to begin the recovery process, however there are many obstacles that serve as barriers to treatment. Such obstacles can include limited family and/or friend support, financial restraints, and childcare issues. These and many other obstacles can interfere and have an impact on treatment success.] Substance use disorders affect men as well as women and prior to counseling either gender, it is imperative to understand the definition and cycle of addiction.

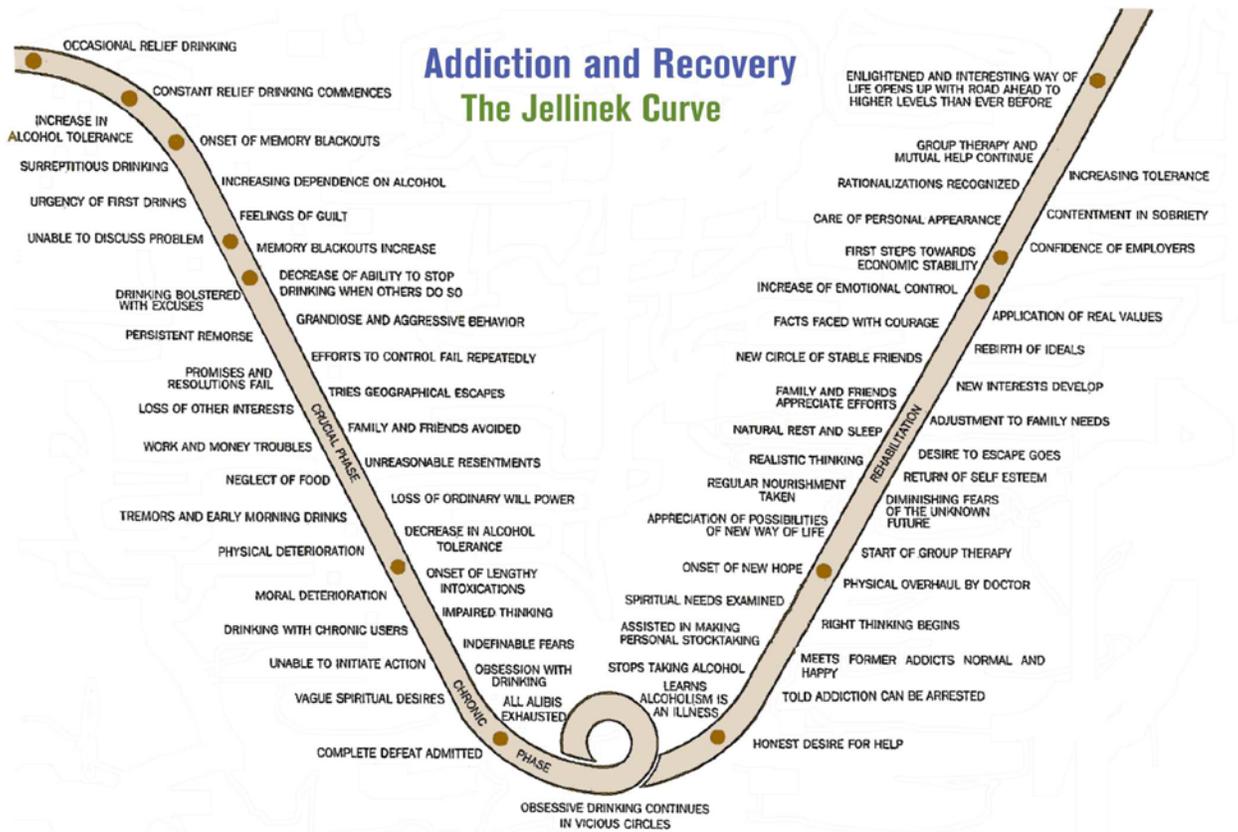
Dr. Jellinek is the first professional to examine the cycle of addiction and discuss addiction in terms of phases of addiction, these phases are: (1) Crucial Phase, (2) chronic phase

and (3) rehabilitation. Dr. Jellinek was a renowned psychiatrist that gave an extensive review of the levels and named them accordingly along with identifying a curve. Dr. E. M. Jellinek provided the first clear explanation of alcoholism and its five phases in his book “The Disease Concept of Alcoholism” (1960). These phases were formulated first in the letters of the Greek alphabet—alpha, beta, gamma, delta and epsilon. He later organized the Greek letters into a cluster of three stages of alcoholism: early (crucial phase), middle (chronic phase) and late stages (rehabilitation) (Faulkner, 2013). Jellinek’s Curve gives an illustration of the progression of alcohol and can be applied to other substances.

Phase	Related to women
Crucial Phase	<ul style="list-style-type: none"> • Family and friends avoided • Tremors / early morning use of the substance. This behavior interferes with the woman’s ability to focus on her duties with her children
Chronic Phase	<ul style="list-style-type: none"> • Onset of lengthy intoxications – this behavior diminishes the woman’s ability to complete her obligations with work, home or school. • Physical deterioration – the woman’s ability to self-care will be minimized and the appearance will decline. Such deterioration includes but is not

	<p>limited to weight loss, hair loss, or dental issues.</p> <ul style="list-style-type: none">• Loss of control (emotionally)• Obsession with drinking and exposes herself / her children to compromising situations
Rehabilitation	<ul style="list-style-type: none">• Begins to take an interest in self and others• Beginning group therapy• Success in treatment becomes a microcosm for success outside of treatment.• Begins to balance life challenges to avoid relapse

Faulkner (2013)



This curve is extremely helpful to keep counselors aware of changes and help anticipate changes in the individual's use and recovery. The curve is also helpful for women's recovery when paying close attention to their signs and symptoms of alcoholism or substance use. Such symptoms may include but are not limited to physical deterioration and an increase in tolerance. These two symptoms are especially prevalent in women and are early signs of alcohol / substance use disorder. Despite showing signs of symptoms, women need to follow-through with the demands of life, such as family and work responsibilities. As a result, these women may not obtain correct treatment in a timely manner and the addiction will advance leading to other medical concerns. The medical concerns that result from physical deterioration may include but are not limited to renal failure, hypertension, diabetes and pancreatitis to name a few.

The medical conditions will then complicate the recovery process creating more difficulties in treatment.

Women who have chosen to enter treatment will be assessed and evaluated to create goals that will promote recovery and enhance the quality of life in recovery. Upon entering into any of the levels of care mentioned previously as defined by the ASAM, the woman will be seen by a qualified health professional with addiction experience also known as a substance use disorder counselor.

Substance Use Diagnosis

This next section will explain how the qualified health professional diagnoses the woman with alcohol or substance use disorder that is mild, moderate, or severe as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM 5) and using screening tools and assessments.

Diagnosis includes completing screening tools to gather information briefly by asking questions related to abuse; assessments are scored tests to identify the severity of the alcohol and/or drug use. There are screening tools and assessments that are useful for beginning treatment for women. An evidenced-based screening tool that is useful is the Short Brief Intervention for Referral to Treatment (SBIRT) which provides brief questions to identify if more assessments are needed to address specific addiction and/or mental health issues. The SBIRT asks three basic questions regarding tobacco products, alcohol use, and illegal drug use/abuse. The SBIRT includes the following screening tools: Alcohol Use Disorders Identification Test (AUDIT), Drug Abuse Screening Test (DAST), and the CRAFFT (Car, Relax, Alone, Forget, Friends and Trouble) Assessment. These assessments are given to gather information and to decide on the level of treatment needed (Madras, Compton, Avula, Stegbauer,

Stein and Clark, 2008). Depending on the answers given by the individual, there is either an intervention of education based on the lack of readiness to change or alternatively, a referral to treatment which is also based on the individual's readiness for changing their use of tobacco products, alcohol or drugs (Madras, et. al., 2008). If there is a desire to change, the clinician can complete assessments that are gender friendly and give enough information for a plan of action to occur in treatment.

There are two assessment instruments that may be useful for clinicians to use for women: Addiction Severity Index (ASI), and Level of Care Utilization System (LOCUS). The two assessments evaluate each part of the woman's life that may be a hindrance to her recovery and coping mechanisms can be created. These two instruments are based on Motivational Interviewing and encourage a conversation between the clinician and the individual.

Addiction Severity Index (ASI) is a 200 item assessment that has seven subscales that take information from the past 30 days and takes a snapshot at drug history, legal, family issues, psychiatric issues, medical status and other forms of support. This assessment is useful for women because of identifying areas of concern that are most noted for women. The assessment has been administered to the following populations: pregnant, homeless and the psychiatric ill, both women and men were equally studied with appropriate norms. The ASI has been used extensively when completing treatment planning and to measure outcomes.

The **Level of Care Utilization System** has three levels: minimal risk of harm, low risk of harm and moderate risk of harm. This assessment outlines the criteria used to closely evaluate the level of care and its intensity (Sowers, George & Thompson, 1999). This assessment also identifies if a woman is in a challenging situation by evaluating the level of stress in her environment. The levels of stress are broken down to low-stress environment, mildly – stressful

environment, moderately stressful environment, highly stressful environment and extremely stressful environment. It is important for the clinician to understand the level of stress in the woman's life to better prepare her with coping mechanisms when the woman begins to make appropriate progress in the treatment plan. The next salient section that is important for the assessment is the level of support. The levels of support assessed in the LOCUS are outlined as: highly – supportive environment, supportive environment and limited support in the environment. As will be discussed later in the course, support is a catalyst for the woman having either success with recovery or relapsing. The woman is also in need of recovery maintenance and a health plan to create an environment that is conducive to recovery and stability within the recovery system. Lastly, the assessment also identifies a co-morbidity rate for the woman and the clinician. This section is most important to woman's health because mental health issues are exacerbated when alcohol or substances are present and complicates the woman's recovery success rate.

Addiction counselors don't rely on these assessments or their own judgment solely, nor do they make guesses about a client's issues, they refer to the criteria as found in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). The DSM is currently in its 5th edition and was published May 2013 by the American Psychiatric Association (APA). The APA is comprised of professionals in the field that value proper ethical care and treatment for individuals diagnosed with mental illness and substance use disorders (APA, 2015). The newest version of the DSM-5 has changed the terminology of addiction to *disorder*, the levels of dependence to mild, moderate, and severe, and specifies the level of care that the individual will need.

The DSM-5's section on Substance-Related and Addictive Disorders lists a combination of cognitive, behavioral, and physiological symptoms for each one of the ten types of substances: alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, stimulants tobacco and other unknown substances (APA, 2013). There are 11 criteria, or circumstances, that the counselor must address when developing the diagnosis:

- (1) Whether the client was taking the substance in increasingly larger amounts over a period of time, and if the individual intended to continue using the substance
 - (2) Any previous unsuccessful efforts to discontinue use
 - (3) The amount of time using and obtaining the drug of choice
 - (4) Whether the client craves the drug physically and psychologically
 - (5) Any inability for the individual to fulfill employment obligations
 - (6) Interpersonal issues that are a result of the substance use
 - (7) Instances of discontinued activities with family and friends
 - (8) Physical hazards that have resulted from substance use
 - (9) Physical and psychological issues related to the substance use
 - (10) Whether or not tolerance has increased over time
 - (11) Any physical withdrawal symptoms that require need medical management
- (APA, 2013).

Once all the criteria have been identified, counselors can determine the specific substance abuse and its severity, as well as its effects on the individual. Severity of the abuse is defined in the DSM-5 as mild, moderate, or severe, and determination is linked to how many criteria are

identified. For example, mild severity is equal to observance of two to three criteria. Severity is moderate if four to five criteria are identified, and it is severe if six or more criteria are identified.

Mary Elise has been diagnosed with alcohol disorder, severe, since she fits the 11 criteria for severe use and also fits the ASAM level for acute detoxification along with a recommendation for inpatient treatment. Mary Elise decided not to take the referral. She returned home and she continued to drink excessively. Mary Elise noticed her energy level was depleting in the morning when she was scheduled to begin work. Mary Elise had a co-worker who introduced her to medication that would give her an “uplift” to complete her work hours. Mary Elise has now started to take methamphetamine during the day and drink heavily in the evening. At this point Mary Elise’s addiction is spiraling out of control. What are some of the consequences she may experience because of mixing the two substances? Will she need to return to the emergency room because of another accident that is caused by using alcohol and the methamphetamine?

Combining other substances

Women that are in active addiction can use various substances; however, alcohol is the main contributor as well as a gateway to the list of other substances such as: methamphetamine, barbiturates, marijuana, cocaine, and heroin just to name a few. The two most influential to women are stimulants and depressants. Stimulants speed up the brain function and create a false sense of energy. In today’s society, women crave energy because so many different opportunities arise and women are accepting the challenge, however, women become drained from taking on other responsibilities and stimulants are often consumed. Caffeine is a stimulant

that is legal, but used daily and at times more than twice in a day can create dependence. The second category of substances most often used by women is depressants. The substances known for being depressants are opioids and alcohol.

Biological Effects for Substance Use

The next section will identify the biological effects from ingesting substances and the differences between men and women.

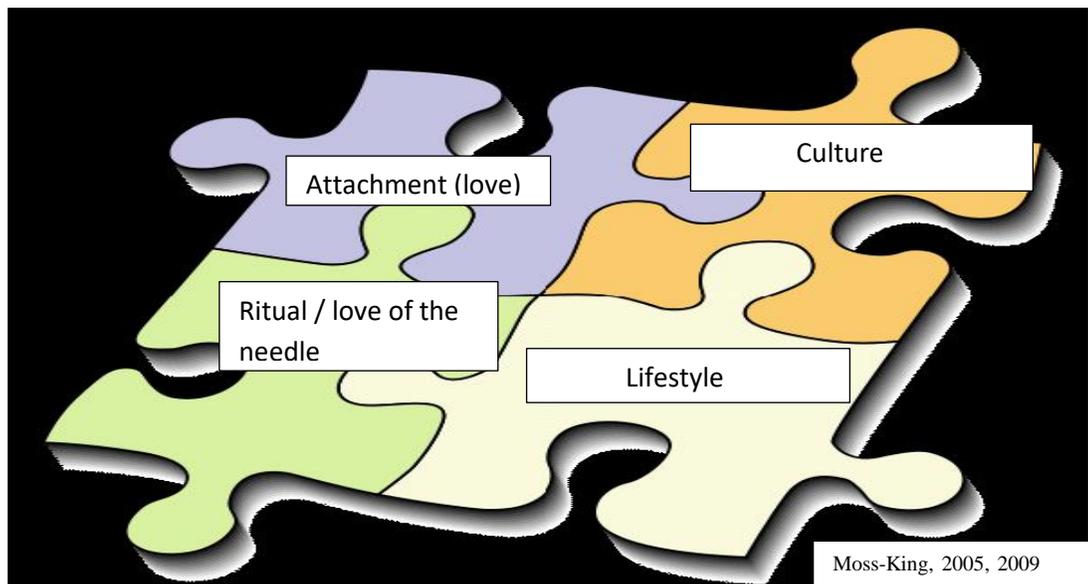
According to the CDC (2013) physicians were over prescribing pain medication disproportionately to women and as a result dependency develops. There are a variety of pain medications that can be prescribed to women or men in chronic or acute pain such as Lortabs, Percocet, and Vicodin among other opioid medications. The main fear for women using opioids is an overdose that may lead to death because of a cocktail mixture that could include alcohol or increasing the amount of opioids used without a physician's authorization (Howard, 2003). . . According to the U.S. Centers for Disease Control and Prevention (CDC) (2013) women are prescribed painkillers at higher doses for a longer period of time. The CDC reported in July 2013 that 48,000 women died of prescription pain medication between the years 1999-2010 (CDC, 2013). The medical issues that will encourage a physician to prescribe opioids to women range from chronic pain to aftercare following a minor or major surgical procedure and the act of overprescribing it has a negative impact on the woman's Quality of Life (QOL).

Females in society have various roles from caretaker, spouse, to provider of the family. Their roles are a significant and enhanced part of our communities, workplaces, as well as households. The main objective of the women when seeking medical intervention is to cease pain and continue activities without interruptions. The woman that becomes addicted is on a very slippery slope in that the end result of addiction is not intentional but happens because of

dependence upon the drug to assist with daily functions and responsibilities. The role of the drug will become a major part of the woman's life and there becomes an attachment: emotionally, physically and psychologically. The use of the drug at this particular time in the woman's life becomes part of a coping mechanism for all of a woman's life experiences. The women become dependent and will use despite consequences personally or vocationally.

According to the research of Moss-King (2009), there are four components of opioid addiction and these components are developed during the process of using and becoming dependent on the opiate emotionally, physically, and psychologically. The first component is the *attachment* to the opiate which forms a special bond that can equate to the love of the drug. The woman begins to depend on the results of the drug and soon the attachment is formed and in early recovery the bond is not easily severed. The second component is the *culture* that is formed with the woman and other using participants. Since there is an abundance of shame and guilt surrounding the use it is extremely difficult to share the opiate use experiences with other individuals that may not be a part of the "using family." Third, the *rituals/love of the needle* become an intricate part of the woman's daily life which affects her quality of life. The woman may begin to plan all activities around the use of purchasing and using the opiate and this will affect her responsibilities as a mother, employee, etc. Rituals could also include the instruments used to administer the opioid which is usually a needle. The woman becomes addicted to the use and physical feeling of using the needle. As a result, the love of the needle becomes an obsession and the woman will continue to deal with these emotions more intensely while in recovery. Fourth, the *lifestyle* is the last component that consists of embracing the world of addiction which includes but not limited to the supplier, the "using" family and other aspects of obtaining the drug intriguing and makes recovery difficult and challenging at times. This fourth component can be a tremendous

disappointment since the lifestyle of opioid addiction is mixed with shame and guilt; the woman may have difficulty with transitioning from a using community to a clean and sober community. The challenging transition usually appears because the woman is having difficulties separating herself from the chaos and the intense stimulation that the lifestyle has brought to the woman's life.



Types of Substances

This next section will discuss the types of substances used as a coping mechanism and the definition of severe use disorder as it pertains to alcohol and other substances.

The most popular substance that is used for relaxation and for coping with stress is alcohol. Alcohol has been used for many years and is used legally as well as socially and can easily become misused and progress into a severe use disorder. The second substance that is most often used by women is opioids and this drug is mainly used for pain or pain management and can lead to abuse or to dependence rapidly. Women attempting to manage opioid use disorder or any substance disorder are accompanied by shame and guilt of their community which is the

main reason women may not seek treatment and this increases the number of accidental deaths as well as long-term addiction that result in other medical issues. Since opioids are used as a coping mechanism there is an attachment formed which is difficult to detach when recovery begins (Moss-King, 2009).

Margaret is 27 years old and started taking opioids because of knee surgery that she had from an injury. Margaret had started taking more than was prescribed because she noticed that the medication was not being effective and Margaret had a need to continue her regular duties at work and as a wife and mother of two. Currently, Margaret's husband Ronald does not know that she has an opioid use disorder and is also not aware of the severity. Margaret has finished the prescription and the doctor will not refill her prescription. The Orthopedic surgeon has referred her to physical therapy. Margaret has attended approximately 3 sessions and at this point states that the physical therapy is not effective and the opioid that she was prescribed is beneficial. Margaret has attempted to stop using without medical assistance and she states she has become consumed with thinking about the pills and how she is able to get more. Margaret has now started to buy her medication illegally and experiences withdrawal symptoms when she does not use. Margaret has been asked to try heroin on several occasions, but she has declined. Margaret states that just one day she could not find any pills and then she used heroin for the first time one year ago. Margaret states that she experienced a faster "high" and she was not spending \$20 - \$30 per pill, therefore she was spending much less. Margaret has now been addicted to heroin for one year and is having difficulty with maintaining her relationship with her husband and her young children ages 5 and 3 are also disconnected. Margaret's home situation is not stable and she is spending less time at home and more time with her using friends; her new found family. Margaret fits the criteria for three of the four

components of heroin addiction: love affair, culture, and lifestyle. Currently, Margaret has not used heroin intravenously she has continued to inhale and smoke mixed with marijuana.

Opioid Medication – Physical Effects

A woman taking opioid medication may have various physical effects that are quite different than men. The woman's reproductive system is affected. The woman suffers from amenorrhea and if she is pregnant she may overlook the symptom of missing her menstrual cycle and attribute this medical condition to the use of opioids instead of acknowledging the possibility of pregnancy. The woman will also have some difficulty with the hormones that create milk in her breasts because of continued use. The woman will also suffer from edema in her lower extremities especially her legs and feet. This will then cut off circulation and this will have negative effects on the heart and compromise the respiratory system. The woman will also need to be aware of exposing herself to dangerous situations while under the influence. This danger could be sexual abuse, domestic violence situations, among other traumatic experiences that could compromise her safety as well as her health.

Currently there is an epidemic of over prescribing opioids in the United States as mentioned earlier. There is documentation that shows physicians had been prescribing the medication for various ailments where there are no other options. Some prescriptions that doctors will prescribe for women are listed below and once the woman does not have access to these prescriptions she may begin taking heroin to receive the same affect at a lesser cost:

Paracetamol / Acetaminophen	Codeine
Dextropropoxyphene	Tramadol

Tapentadol	Anileridine
Alphaprodine	Pethidine
Hydrododone	Morphine
Oxycodone	Methadone
Diamorphine	Hydromorphone
Oxymorphone	Levorphano
7-Hydroxymitragynine	Buprenorphine
Fentanyl	Sufentanil
Bromadol	Etorphine
Dihydroetorphine	Carfentanil

(Opioids.net, 2014)

Soon these women understand that the pain has been alleviated because of the prescription, but now there is a false sense of security that can only happen with the use of the opioid and then dependence upon the opioid gradually happens because the drug is used for various reasons. Research has shown that the use of a drug continuously is the result from an individual attempting to cope with a stressful situation (Hassanbeigi, Hassanbeigi and Pourmovahead, 2013.) Stressful events can happen simultaneously or can happen separately and if a woman does not have the appropriate coping mechanisms dependence upon a drug or alcohol can become the “crutch” to handle situations.

Coping with Stress through Intervention

This next section will explain stressful situations and the need for developing appropriate coping mechanisms through treatment. As mentioned earlier, the lack of coping mechanisms and stress are the number one causes of a relapse or continued use. According to Hassanbeigi, et al (2013) there is a relationship between opioid dependence and stress. Research on the mechanisms underlying drug disorders has shown that stress is one of the strongest predictors of drug use and developing coping mechanisms is an important factor in mediating the effects of stress on opioid use. These researchers discovered that with more stressful life events and the lack of coping skills /strategies, the opioid user will attempt to manage these events by the use of opioids giving a false confidence to overcome the stressful events. Such stressful events include, but are not limited to family, employment and marital issues. There is also research that states individuals in opioid recovery have more stress because they may be dealing with continued addictive behavior that may be contributing to the ineffective coping strategies as well as low self-efficacy. (Hassanbeigi, et al., 2013) Some examples of stress include but are not limited to exposing themselves to individuals that are continuing to use heroin or other drugs and this will enhance the chances of a relapse. Other stressors include family, vocational and social – emotional stress that require coping mechanisms to successfully begin and continue recovery. The opportunities for a relapse occur because of the exposure to the drug environment and acquaintances along with the desire to use increases along with the accessibility to heroin. The majority of heroin users, and especially women, have a lack of confidence to use coping strategies / techniques when faced with a compromising situation surrounding drugs or alcohol.

Mindfulness is a form of meditation and has been effective in the treatment of substance use disorders and has been effective in recovery. An example of a mindfulness strategy would

be for the woman to begin breathing gently and counting slowly; this begins the calming effect and will increase the woman's ability to think clearly. The woman will begin to concentrate on one area of the room or one object and focus her mind while breathing slowly. The next coping technique is for the woman to use an intervention strategy: motivational interviewing to non-emotionally rationalize a situation. Since a woman's emotions fluctuate often because of hormone changes and especially if in active addiction, the hormones are imbalanced creating irrational decision making. The mindfulness technique in conjunction with motivational interviewing, taught by a counselor will assist the woman to identify her willingness to change in her circumstance and discuss the strategies to change. The woman will need a strategy to remove or to relieve the negative emotions and this is where exercise or some sort of physical activity will be beneficial. The information regarding the physical activity and the results especially for a woman in heroin recovery or active addiction plays a major role for recovery to be successful. Both the strategy and coping mechanisms will increase the woman's self-efficacy (confidence) , and her self-worth (self-esteem) which will increase her chances of recovery..

A woman may fluctuate in her readiness to change throughout use and recovery. Prochaska and Velicer (1997) examined this readiness through the model of stages of change.: Stage 1 is pre-contemplation: the individual is unsure if recovery is an option along with the possibility of being in denial about her addiction; Stage 2 is contemplation: which is explained as an individual is deciding if recovery is a good choice; Stage 3 is the preparation stage: which is the stage the individual begins to put together strategies toward slowly transitioning toward change; Stage 4 is the action stage where the strategies are put into place and actually "acted" out toward change; Stage 5 is maintenance where the transition is successfully completed and the individual is continuing to enhance their techniques to make the change permanent.

Understanding these stages of change are vital for a counselor to continue to revisit because various situations that a woman may experience affect the stage of change she is currently in as well as affecting the maintenance stage of recovery. The therapist usually understands stages by asking the woman to put their level of change on a Likert scale usually between 1 and 5. The individual will also state willingness to change and explain the number chosen. At this point motivational interviewing language is used to identify the changes needed to increase her score.

Readiness for Change for Mary Elise: The therapist will use motivational interviewing to discuss Mary Elise's willingness to attempt recovery. Currently Mary Elise is at the pre-contemplation stage of Prochaska and Velicer's stages of change. The therapist will evoke thoughts of change by having her (1) identify why this change toward recovery is difficult; (2) discuss with her that the counselor accepts the decision and wonders if Mary Elise is satisfied with her decision not to move toward recovery; (3) Ask Mary Elise on a scale of 1-3 how willing is she to change toward recovery and the strategies to be in place to move up the scale or stay the same. Once Mary Elise identifies the strategies then the barriers will be discussed – at that point coping mechanisms will be developed to handle the barriers that may interfere with her choice to change toward recovery.

Review Thought Questions:

1. Why are women prescribed opioids more often than men?
2. What are some emotions that women experience when using drugs or alcohol?
3. What are the ASAM Levels of treatment?
4. What recommendations would you give Margaret and Mary Elise?

It is important for qualified health professionals who are working with women to recognize that women are placed into more than one category of life responsibility at a time and this can be very stressful since each category represents a specific duty within their community at home as well as outside the home. The stress can become overwhelming and the substance takes the place of coping skills and soon the woman will need to be taught non-drug coping mechanisms to handle her stress in a healthier manner. First, however, it is important to understand the results of stress and the emotional impact when women are in the midst of challenging situations and the unraveling of the circumstances can negatively affect the woman's mental health. During the mental health disruption the woman may depend on the opioid to deaden the feelings or to actually function well. This next section will focus on three mental health diagnoses that appear to affect women on a broad and / or minimal scale: depression, Post- partum depression and Post-traumatic stress disorder.

Vignette : Depression

Louise is a 22 year old who is a recent college graduate diagnosed with depression at age 13. During Louise's high school years she attended counseling sessions to manage her depression symptoms. While in college Louise experienced loneliness and then the depression symptoms reoccurred and an antidepressant was prescribed. Louise was able to manage her depression symptoms well while she was in college, however, since graduation there have been drastic changes in her life. The first change is that she does not have an assigned counselor since leaving her college campus. The second change is that she is unable to find employment and is now starting to feel depressed and lonely once again. The third change is that Louise is independent and is afraid she will not be successful with adult responsibilities. These three changes have increased the depression symptoms.

Thought Questions:

1. What coping mechanisms can be discussed in the counseling session?
2. What coping mechanisms can be written on the treatment plan for the depression symptoms?

Vignette Post – Partum Depression:

Louise is now 27 years old. Louise attended counseling 5 years ago and she became independent and became involved with a student she knew in college. Louise and the student Larry married and Louise is now 6 months pregnant. Louise states to Larry that she is feeling very sad during the pregnancy. Larry suggests that Louise speaks to the obstetrician. Louise does follow the recommendation of Larry. The obstetrician reviews the symptoms followed by a referral to a mental health therapist who administers the Beck Depression Inventory. The mental health therapist discusses the results of severe depression and explains that women who were depressed prior to pregnancy have a greater risk of depression symptoms during pregnancy and thereafter. Louise's mental health therapist provides education on post partum depression and also sets Louise up with resources to be proactive with the post-partum depression.

Thought questions:

1. What treatment plan issues can be addressed regarding post partum depression?
2. What strategies can be created in session that will encourage Louise?

The Role of Behavioral Health and Addiction

Depression

There are several reasons that depression occurs with women including three factors: genetics, brain chemistry related to hormones, and life's stressors. There are several hormones that play a significant role in depression. The three that researchers have discovered have a direct relationship with women's depression include: estrogen, progesterone, and cortisol (Body Logic, 2016). At times literature states that if these hormones are imbalanced this could also increase the symptoms during menopause. The other important addition is that stress whether it be internal or external has a negative effect on these hormones and can increase the likelihood of weight gain in the midsection. This imbalance can affect the woman's personal life as well as her work relationships.

This next section will identify the hormones that have an effect on women and the function of each hormone.

Hormone	Function
Estrogen	Increases serotonin and promotes sleep. If there are low levels of estrogen it affects sleeping patterns and also women are known to feel sad and hopeless
Progesterone	Assists in balancing estrogen and is a natural antidepressant. Low levels promote sleeping patterns that are unhealthy and moodiness.

Cortisol	This is dangerous for women if the levels rise too high or too low. The women will gain weight in their midsection (belly fat). The levels is they are not balanced will also increase cravings for sugar and the woman may experience moodiness.
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(Stanton & Tweed, 2009).

Women may have depression symptoms in addition to their substance use disorder symptoms such as withdrawal, cravings, nausea, tremors, skin infections to name a few. It is vital that counselors give the women information on depression when treatment begins to alert them of the signs and symptoms. Differentiating between addiction and depression will empower the women to have effective treatment and continuity of care. Some of signs of depression are: feeling overwhelmed, sadness that is continuous, high levels of irritability, inability to rationalize or to problem solve are just a few symptoms that the woman can communicate with her counselor or even primary care physician or OB / GYN. It is vital that the woman communicates her struggles with not only a medical professional but also her family, friends and support system. Support systems could include mentors or sponsors from a 12 step program. There are several support mechanisms that will need to be put in place to provide a safety net for the woman and current situation along with preparing for future situations.

A woman may experience depression during any time of her life and addiction complicates recovery and it becomes vital for a counselor / therapist to provide proper education and supports. If a woman is depressed prior to pregnancy she is a high risk for post- partum depression. There is also a concern for women who are already prescribed medications and the

use of these medications during pregnancy. In the next section we will discuss depression during pregnancy and the use of medication.

Depression During Pregnancy

As discussed earlier, hormone levels play a significant role with the diagnosis of depression. These hormones begin to fluctuate even more when the woman is pregnant and this may cause more challenges. The media has created a fantasy image of how a woman should be or experience pregnancy. Studies have shown that more than 50% of pregnant women suffer from depression while pregnant. Also studies have also shown that women who experience depression prior to becoming pregnant will run a higher risk for experiencing depression while pregnant (WomensHealth.gov, 2017; Zauderer, 2009). Women may assume that they are isolated and there are no supports available, on the contrary, supports are available but only if the woman communicates her needs appropriately to the OB / GYN or her counselor.

There are medication options if the woman chooses and the doctor may offer certain selective serotonin reuptake inhibitors (SSRIs). These SSRIs are generally considered an option during pregnancy: citalopram (Celexa), fluoxetine (Prozac) and sertraline (Zoloft). Studies have shown that there were low percentages of birth defects for infants exposed to SSRIs. (Reefhuis, Devine, Friedman, Louik, Honein, 2015) As a result, a low dosage is recommended along with other non-medication remedies such as meditation, yoga, and simply being aware of self-care. Self-care efforts such as eating well and getting enough rest daily and not using any illegal drugs or drinking alcohol can have a positive impact on the depression level of the woman.

Usually depression and anxiety go hand in hand and the medication prescribed is usually Xanax which is a highly addictive benzodiazepine and has a very negative effect on a woman's health in particular when the woman decides to discontinue use. Withdrawal for the woman is very intense resulting in nausea, trembling, and possible seizure activity. If the woman decides to continue with Xanax while pregnant the infant will also experience acute withdrawal symptoms after birth also known as Neonatal Abstinence Syndrome. As a result of the after birth difficulties and the negative impact on the woman's health, the administration of Xanax for a woman during pregnancy is not recommended.

Depression during pregnancy results because of the imbalance of the hormone serotonin. This imbalance can be biological or the result of an unbalanced diet. It is highly recommended by the CDC as well as other health organizations that the woman has a balanced diet with a high concentration of folic acid and green leafy vegetables along with light exercise to increase the likelihood of balancing the hormones that interfere with the emotional stability of the woman during pregnancy. In the event that depression occurs during pregnancy there is a high occurrence of post-partum depression. The counselor can counteract this by constantly checking in with the woman during visits as well as identifying the level of depression by administering assessments such as the Beck Depression Inventory.

The Beck Depression Inventory (BDI) is a 20 questionnaire that identifies if an individual is mildly, moderately, or severely depressed. If the results of the BDI are a concern, a referral to a licensed mental health counselor is highly recommended. At this point the woman can attend groups for depression and meet with their counselor to develop coping skills to manage the depression and the anxiety for a safe pregnancy.

Post-partum Depression

Post-partum depression is a type of psychosis after childbirth that has been researched for many years for women who are not in active addiction. There has been limited research for the women in active addiction or recovery who give birth and soon experience post-partum depression. Post-partum is a mixture between anxiety and major depressive disorder. According to the DSM- 5, this specific depressive disorder can appear four to six weeks following delivery; or if prior to delivery, specified as peripartum onset. For women that have suffered from depression or anxiety prior to their pregnancy, there is a fifty percent chance that the woman will experience more intense symptoms of depression or anxiety after childbirth. These women will also double their possibility of post-partum for their next birth.

Biological Features of Post-Partum

A normal pregnancy has endocrine changes that would be considered pathological. However, a woman that is pregnant and has delivered has an increase in the following hormones: ovarian steroids, the hypothalamic-pituitary-adrenal axis, and the serotonergic neurotransmitter system, the thyroid system, and inflammatory markers (Skalkidou, Hellgren, Comasco, & Sylven et. al, 2012). A summary of Skalkidou et al's explanation can be seen in the following table:

Ovarian Steroids	Involved with the menstrual cycle
Hypothalamic – pituitary-gland	Produced by the hypothalamus and the pituitary gland and is the response to stress.
Serotonergic neurotransmitter system	Development of Serotonin in relation to depression.

Thyroid system	Involved in the endocrine system and controls body weight, menstrual cycle, cholesterol levels
Inflammatory Markers	Increase of protein in the blood that may cause inflammation with a type of bacteria in one or more of the following areas: the pelvis, ovaries, fallopian tubes, afterbirth womb

There are adaptive changes during the actual delivery process and the nursing process that could create a chemical imbalance. This chemical imbalance can lead to depression or psychosis. In addition to the hormone imbalance there is the sudden lack of sleep because of the mother caring for the newborn; the sleeping pattern changes suddenly along with the stress of motherhood can have a negative effect and the onset of depression begins. It is important that counselors and women alike understand that environments may have a negative effect on women and post-partum symptoms may begin. . These symptoms may be alarming and/or disappointing to some women because they had such success in her recovery during the pregnancy and now experience regression from a maintenance stage to a pre-contemplation stage of relapse.

Assessments for Post-Partum Depression

Post-partum depression may happen following the birth of a child. As discussed earlier the endocrine system and inflammation play a large role with the onset of post-partum depression. There are assessments that will be able to assist a therapist to treat the condition appropriately. The Edinburgh Postnatal Depression Scale (EPDS) is one assessment that is used

and reviews the mother's emotions within a seven day period. It is highly recommended that the mother complete the assessment without the assist of others except if she requires reading assistance. Once scored, if the final score is exceeding 13 the mother may be suffering from depressive symptoms. At this point the next evaluation would be the Beck Depression Inventory to give the severity of the depression along with determining the next level of care recommended by the qualified health care professional.

A second assessment, the Maternal Lifestyle Post-Partum Questionnaire, is the one assessment that asks indirect questions about consumption of beverages other than coffee or milk and also identifies nutritious meals. This assessment gives the clinician insight to the lifestyle of the mother and the ability to offer suggestion / recommendations.

The next two sections will focus on post-traumatic stress disorder and the use of trauma informed care along with post-partum depression. These two disorders are recognized by the DSM 5, and there are more empirical studies in the literature to inform counselor and therapists. Post-traumatic stress disorder and post-partum depression are important for a clinician to be aware of in order to assist with relapse prevention strategies for the woman to engage in treatment.

Post-traumatic stress disorder

Studies have shown that women have used illegal substances and alcohol to cope with a traumatic life event (McLafferty, Becker, Dresner, Meltzer-Brody, et. al (2016). The alcohol or drug has been used as a defensive mechanism to mask to hide emotions related to the traumatic life event. Many of the women have stated that the trauma was the result of some type of abuse: domestic violence situation, sexual abuse, emotional abuse or environmental violence. Women

who are diagnosed with Post Traumatic Stress Disorders will re-experience the event many times over and the woman will also state that she has intense emotions over the event. The intense emotions are present when the woman is thinking about the situation or may have a confrontation with her perpetrator. The woman may experience PTSD a few months following the tragic event or the diagnosis is not given until many years later. PTSD is one of the behavioral health diagnoses requiring continuous assistance and coping mechanisms to continue a woman's path toward recovery. There are three categories of symptoms of PTSD that the clinician should be aware of:

Re-Experience	Women may experience the event many times over from flashbacks, physiological stress i.e. upset stomach, minor aches and pains.
Avoidance	The women will avoid many objects or people that are related to the traumatic event. The woman may not discuss the event and this will cause disenfranchisement.
Increased Arousal	The women become very intense and on edge with a constant reminder of the event. These women also have continuous anger and irritability.

(namimi.org, 2016)

Since PTSD is a mental health disorder that can affect women because of situations such as a sexual assault or domestic violence, the women could have one of the three symptoms of PTSD. Therapists will need to use strategies that have been empirically studied to show a

positive effect especially when working with these women. As noted earlier individuals that are diagnosed with PTSD may have increased arousal and for some the intensity of the arousal may increase the need for substances to numb the physiological feelings. Women who are attempting to numb the arousal may do this by using substances such as depressants which decreases the anxiety from the arousal.

PTSD – DSM 5

According to the DSM 5, Post Traumatic Stress Disorder is now under the category of anxiety disorders. The DSM 5 has a more detailed definition that includes sexual assault, and continued exposure environmentally. This diagnosis does not exclude other persons that have experienced a traumatic event, such as emergency medical technicians, police officers and other environmental factors (APA, 2013). The DSM 5 has described four areas that are re-experienced as “avoidance, negative cognitions, mood and arousal” (APA, 2013 p. 2).

Re-experiencing covers spontaneous memories of the traumatic event, recurrent dreams related to it, flashbacks or other intense or prolonged psychological distress. Avoidance refers to distressing memories, thoughts, feelings or external reminders of the event.

Negative cognitions and mood represents myriad feelings, from a persistent and distorted sense of blame of self or others, to estrangement from others or markedly diminished interest in activities, to an inability to remember key aspects of the event.

Finally, arousal is marked by aggressive, reckless or self-destructive behavior, sleep disturbances, hyper-vigilance or related problems (APA, 2013 p. 271-272).

Women who are diagnosed with PTSD may have experienced sexual trauma, and / or domestic violence just to name a few and cope with these circumstances by using drugs or alcohol. According to the National Institutes of Health (2015) and the Center for Disease Control (2016) substance abuse is the main reason that there are domestic violence cases which often result in serious injury and even death; most importantly, women make up the vast majority of these profound statistics.

PTSD Assessments

The most challenging for a counselor, community helper, or social worker is to identify if there has been traumatic life events that may be reoccurring either in the form of nightmares, or flashbacks or by human contact. Usually questions are asked during an intake interview or during the biopsychosocial assessment and the information may be shared. However, most times the information is not shared, but with the assistance of a non-invasive questionnaire the information can be discussed and pivot the conversation toward creating a plan to confront the trauma and to relate the trauma as a trigger to use drugs or alcohol.

A non-invasive questionnaire is the Life Events Questionnaire which consists of 16 questions about traumatic events and the woman can identify if she has had this experience in her life. If there are answers regarding the life event, the counselor, social worker, or therapist can use this questionnaire to stimulate conversation and move toward solutions in recovery. Weathers, Blake, Schnurr, Kaloupek, Marx and Keane (2013) explain that the Life Event Check list is a standard self – report to identify if one or more of the events actually occurred. The authors also stated in their research that it is an extended self-report to establish if there was an event more salient than another that occurred. Once the event check list is completed the woman can be interviewed and the DSM 5 criteria will be reviewed before a diagnosis is established. The Life Events Checklist created by Blake, Weathers, Nagy, Kaloupek, Charney, & Keane in 1995 is similar to a Likert scale except it is not a ranking. The choices of responses are: “Happened to me; Witnessed it; Learned about it; Part of my job; Not sure.” Weathers, et al (2013). Depending on the response, the traumatic event may be the trajectory toward beginning therapy honestly. There are other PTSD assessments available and these can be used with women to explore trauma and the surreal of the event. Some of the assessments are: Trauma

Assessment for Adults, Trauma History Screen, and Evaluation of Lifetime Stressors to name a few for choices that explore events that could potentially lead to using alcohol or substance to cope with the past events

A woman that decides to be clean and sober may have decided to not be disenfranchised and would like to deal with the traumatic event to begin coping and then healing. The therapeutic techniques that have been empirically studied and show promising results are Eye Movement Desensitization Rehabilitation (EMDR), and Mindfulness techniques.

Therapeutic Treatment for Post-Traumatic Stress Disorder

Eye Movement Desensitization and Reprocessing Therapy (EMDR)

Eye Movement Desensitization and Reprocessing Therapy (EMDR) is a direct effect therapy developed by Dr. Francine Shapiro in 1988. According to Shapiro (2014), EMDR is an effective therapy for trauma victims and is recognized by the American Psychiatric Association and the U.S. Department of Defense. A therapist will be required to go through specialized training to become a certified EMDR specialist. This type of therapy is known as a comprehensive and integrative psychotherapy approach and can also be eclectic when in combination with Cognitive Behavioral Therapy as well as Mindfulness (Shapiro, 2014). EMDR was created to discover and identify traumatic feelings that create negative emotions; the result is that the emotions can lead to anxiety and or depression which can be masked with addiction to control the overwhelming emotions. Self-medicating is the long-term result of the substance user not addressing the underlining issue that are negative emotions from a past experience. Some underlining issues could be a traumatic event such as childhood sexual abuse or an event that resulted in Post-Traumatic Stress Disorder (PTSD) (Garland, Davis, & Howard, 2012; Asberg & Renk, 2012).

The goal for using EMDR with the SUD individual is to gently reach into the negative emotions and process as well as confront these emotions in relation to the SUD. Asberg and Renk (2012) state that negative events are at times buried and can be the driving force behind the substance use disorder. The negative events require processing followed by coping skills training in conjunction with self-help groups to assist the individual through the treatment process.

The procedure of EMDR treatment is eye movement with focusing on a light or focusing on tones or taps through earphones. While the individual is concentrating on the stimulus they are attending to the memory that is painful / traumatic and identifies current triggers for the memory that may be suppressed along with discussing the anticipated future experience which may have resulted in the negative feeling (Shapiro, 2013).

The EMDR has eight phases of treatment. Phase one (history taking) includes the therapist taking a history and discussing the reason for attending therapy. In Phase two (Preparation) the therapist evaluates the individual's readiness to handle emotional distress and if the individual has appropriate coping skills. Phase three (assessment) is organizing the groundwork for the EMDR sessions with three specific areas: (1) explanation of where the trauma took place including the emotions or physical sensations attached; (2) discuss any negative beliefs related to self as a result of the trauma; (3) discuss the positive belief of the substance user associated with the present emotion. Phase four (desensitization) is the opportunity that the substance user has to focus on the negative self-beliefs and emotions that are disturbing along with physical sensations associated with the trauma. Phase five (installation phase) where the substance user focuses on the positive self-beliefs that will eventually replace the negative beliefs surrounding the traumatic event. Phase six is the body scan where the

substance user focuses on the physical sensations eventually replacing with positive thoughts to resolve the negative stimulation. The goal of phase six is for the substance user to discuss the trauma without negative physical sensations that will re-traumatize the user. Phase seven is the closure segment where the counselor practices coping techniques and relaxation exercises to increase a healthy balance. Finally, phase eight is the reevaluation period where the counselor reviews the substance user's responses and progress (Bartson & Smith, 2011; Shapiro, 2014)

According to Shapiro (2014) the majority of the EMDR participants' state that the stress associated with the memory is greatly diminished or eliminated totally. Since the memory produces minimum negative emotions, the individual will begin to have positive life changes which eventually affect behavior by using guided imagery and Mindfulness Technique Training.

The Mindfulness Technique

According to Brewer et al. (2009), the mindfulness technique is an avenue to effectively control stress and undesirable feelings that could result in a relapse. Individuals who are in early recovery have perennial impulsive thoughts that can lead to using the drug of choice if the individual gives in to these impulses. Witkiewitz, Bowen, Douglas and Hsu (2013) examine mindfulness in terms of controlling craving. Their study shows mindfulness is effective in lowering self-reported cravings on scales when acceptance, awareness, and non-judgmental behaviors were measured. An individual who uses substances is learning, through the language of the therapist, to "live in the moment" of the experience by using all senses, including the mind. O'Connell's (2009) study examined the use of mindfulness in an inpatient setting where the patients would "sit" with their emotions. This entailed focusing on a certain part of the body and meditating. The result of the study was that the participants were able to regulate their thoughts. Regulating their thoughts included, but was not limited to, the participant being aware of his or

her disorder and the thought process of compulsivity. Although this study was completed in an inpatient residential facility, mindfulness can be an adjunct to treatment at all levels of care mentioned earlier in the chapter.

Brewer et al. (2009) conducted a study comparing the effect that mindfulness and cognitive-behavioral therapy had on participants' responses to personalized stress. The results showed that mindfulness techniques were more effective than cognitive-behavioral therapy in reducing patients' response to psychological and physiological stressors.

Effective Theories for Women

There are theories that have been known to assist women through the process of recovery. As mentioned earlier in the course, counseling techniques are a major part of a woman's successful recovery. The following techniques are known to be successful when working with women: Motivational Interviewing, Motivational Enhanced Therapy and Trauma Informed Care.

Motivational Interviewing

Motivational Interviewing (MI) was developed in Norway in 1982 and published in 1983 by William Miller, Ph.D. and Stephen Rollnick, Ph.D. (2013). Motivational interviewing can be used during individual therapy because it is client centered and directed as demonstrated in the past by Carl Rogers (Miller & Rollnick, 2013). MI is a way to motivate an individual toward recovery when there is resistance along with resolving ambivalence by increasing internal motivation and increasing self-efficacy (Miller & Rollnick, 2009, 2013). The individual may be contemplating recovery and the spirit of MI evokes healing and encourages the client to bring forth positive ideas toward the treatment process. These positive ideas are the results of a therapeutic relationship that is goal directed and client centered and increases self-efficacy (Lewis, Dana & Blevins, 2015). The therapeutic relationship consists of the counselor having

empathy and unconditional positive regard to assist the individual to facilitate change. Change is the result of a required respectful exchange of ideas between the counselor and the client during the sessions (Miller & Rollnick, 2013). The flow of Motivational Interviewing is combining MI methods and the MI spirit to elicit motivation and plans toward change along with strengthening commitment for change while rolling with resistance.

Motivational Interviewing is a series of techniques to guide the therapist to evoke change within the woman's life environment. The change is intrinsic which promotes dedication to make the shift in thinking as well as in behavior. MI is known to be beneficial for women because it allows them to talk without interruption and encourages a therapeutic relationship that is based on trust as well as to have a clear understanding of the goals toward making the change (Handmaker, Miller, Manicke, 1999).

A key to each of the effective approaches to working with women is the therapeutic alliance, or the relationship between the client and counselor. It is an essential component of therapy. The fundamental principle of the therapeutic alliance is listening to the individual without passing judgment verbally or nonverbally. The relationship is the variable for predicting client response and the counseling outcome. Duff and Bedi (2010) concluded that validation was an important part of the therapeutic alliance; that nonverbal communication and positive regard were both effective toward enhancing an individual's self-efficacy and bringing about a positive outcome. Another part of the therapeutic alliance is the language used by the counselor to create motivation toward behavioral changes in recovery. There are five core skills to create a positive therapeutic relationship during an individual counseling session: asking open questions (invites the substance user to consider elaborating on their answers and thoughts); affirming (depends on the substance user's inner strengths and amazing efforts toward the recovery process); reflective

listening (the counselor continues to engage the substance user by allowing exploration and consideration of previous statements made in the session); summarizing (presenting material discussed before and encouraging more conversation on a deeper level to explore the substance user's statements; and informing as well as advising (the counselor will provide information and advice only by request of the substance user (Miller & Rollnick, 2013).

The Method of Motivational Interviewing

There are four processes used in the method of MI and the processes need to sequentially follow each other (Miller & Rollnick, 2013). The four processes are engaging, focusing, evoking and planning. It is important to recognize that the first step is the engaging process, which lays the foundation for focusing on the goals regarding the presenting problem. Once trust is established and the environment is safe, the individual can focus on developing goals that are evoked by change talk and planning for change can begin.

1. *Engaging:* The beginning of the MI process is the engaging phase which is the moment that the counselor and the client connect and make a decision to work together toward change in a therapeutic relationship.
2. *Focusing:* The counselor will begin to focus on the presenting problem and begin to provide direction for the client. The counselor will use MI to identify the goals that the client may have toward change and utilizing the therapeutic relationship to focus on the change.
3. *Evoking:* The counselor will draw out arguments toward change allowing the client to discuss their feelings about change and move quickly toward planning.

4. *Planning*: The planning stage is also key to being ready for change. This is the balance between talking and thinking about change where actual steps develop for change (Miller & Rollnick, 2013; Lewis, et. al., 2015). The planning process stage will have a combination of commitment to change and creating a specific plan. The counselor will discuss the plans and encourage the client's autonomy to make a decision and thus change talk emerges.

The motivation to change is definitely in the spirit of MI and this next section focuses on the components of the MI spirit that the counselor brings to the therapeutic relationship.

The Spirit of Motivational Interviewing

Motivational Interviewing is a partnership between two experts, the counselor and the counselee. The counselor who embraces the spirit of MI finds success with their client accomplishing goals toward recovery. The counselor has a complimentary therapeutic relationship with the client that is an honest and collaborative effort with the counselor forfeiting the leadership role in the session. The counselor will encourage the client to have autonomy and be the expert while the counselor continues to guide. As this system works toward goals of behavioral changes the client's confidence level is elevated to make independent decisions about their recovery and appropriate lifestyle changes. The spirit of MI is therefore utilized to awaken the client's motivation and the resources they have available for change. This is done by incorporating the four spirits of MI: acceptance, compassion, evocation, and collaboration (Miller & Rollnick, 2013).

Acceptance.

In the spirit of MI and the belief that the client is also an expert in the therapeutic relationship the counselor accepts the individual's thoughts and their contributions to the session. This resurfaces the work of Rogers in the aspect of absolute worth, autonomy support, accurate empathy, and affirmation (Miller & Rollnick, 2013).

In the spirit of MI the counselor is consistently working through ambivalence by demonstrating during the session that there is trust between the two experts and there is respect for each other's worth. The counselor also has respect, without judgment, for the client's ability to choose direction(s) thus providing autonomy support for the client. The act of accurate empathy is illustrated by understanding the client's worldview along with affirming the client's strong points and intentions toward change.

Compassion.

The counselor is intentionally working with the client to show that the client's needs are priority and promotes the client's welfare. This characteristic in the MI counselor will create a welcoming environment where the client feels important and therefore will begin to feel comfortable toward discussing change.

Evocation.

The spirit of evocation is the counselor's interest and understanding of the client's perspective and wisdom toward change. It is the belief that the clients have the power within themselves to rationalize and to promote change by consistent encouragement from the counselor to extract these ideas.

Collaboration.

The combination of evocation, compassion, and acceptance with the assimilation of empowerment to the client from the counselor is a movement toward change. The sense of empowerment that the client has is embodied with the knowledge that the client's thoughts are valued and decisions are respected. In the true sense, the counselor and the client are working together to overcome ambivalence by increasing motivation toward change.

The role of collaboration is impossible without the development of a positive therapeutic relationship between the counselor and the client. Counselors use the five core skills mentioned in the therapeutic alliance section with a client centered approach to encourage change talk (Lewis, et. al., 2015). The change talk that is spoken by the individual becomes a microcosm outside of the therapeutic environment as the individual works through the ambivalence. The counselor works through ambivalence by evoking change talk keeping in mind that ambivalence can be toward change or sustaining the precipitating problem.

Change Talk

Miller and Rollnick (2013) define change talk as a self-expressed language that is an argument for change. The language that the client is speaking is self-motivating and illustrates commitment toward change. The client that is speaking change begins with *preparatory change talk* and gradually transitions to *mobilizing change talk*.

Preparatory Change Talk.

Preparatory change talk has four components: desire, ability, reasons, and need (Miller & Rollnick, 2013). The first component is desire which illustrates an individual's wishes and hopes

toward recovery. The second is ability, which is the individual's self-perception toward being clean and sober and the intrinsic motivation to acknowledge and envision sobriety as an actual possibility. These are the sentences that have the "could" and "would" as part of the change talk (Miller & Rollnick, 2013). The third is reasons, these are statements that support or do not support the ability statements. If the counselor recognizes that the individual is struggling with ambivalence toward sobriety in relationship to lifestyle changes and has stated reasons that were for change or against it, the counselor could do a decisional balance as suggested by Miller and Rollnick.

The fourth component is need, which expresses the immediacy toward change. Once the counselor observes the change in language the individual is now moving toward *Mobilizing Change Talk*.

Mobilizing Change Talk.

Mobilizing change talk is moving toward resolving the presenting problem by hearing the language of commitment and activation. The language of commitment is the intent to change with minimal hesitation. Such statements from the client can be "I promise to attend self-help meetings to maintain my sobriety." These statements demonstrate that activation is the next step toward accomplishing the sobriety goal and the client is willing to give direction toward the goal (Miller & Rollnick, 2013).

Activation is the language the counselor will hear in the session and it is direction motivated along with taking steps toward change. Previously, our example was "I promise to attend self-help meetings to maintain my sobriety." The client can be more concrete with this action and take steps by stating: "I will be attending self-help meetings three times per week."

Not only was the client moving toward action, but the client illustrated the steps that will be taken toward maintaining sobriety (Miller, Rollnick, 2013).

In conclusion MI is effective because it allows the client to be the expert and also encourages positive thinking and talking which then allows an active plan to take place. The client creates this action plan at the same time the counselor utilizes the methods and the spirit of MI effectively developing a safe environment for strength and growth creating a microcosm to implement goals toward recovery.

Motivational Enhancement Therapy

Motivational Enhancement Therapy (MET) incorporates feedback from structured assessments and uses MI to provide feedback for the personal findings. MI is utilized to have a productive conversation regarding the assessments in a directive approach intended to strengthen the client's commitment to change and increase self-efficacy (Lewis, et. al., 2015; SAMHSA, 2013). The use of the structured assessments promotes the client to develop intrinsic motivating goals along with increasing self-efficacy while working with ambivalence. The method of motivational interviewing and the spirit of motivational interviewing are used during the MET sessions with the ultimate goal of change talk for the client to set goals and to be successful. Burlew, Montgomery, Kosinski & Forcehimes (2013) compared African American substance users that were administered MET and other African Americans that were administered counseling as usual (CAU). Both measured readiness to change. The results were that the individuals with MET reported fewer days of substance use per week and were ready for change more than the participants that had CAU. Also according to Korte & Schmidt (2013) the Anxiety Sensitivity Index was administered and MET was used to discuss the results of the evaluation along with

developing goals. The results were in favor of MET reducing anxiety sensitivity and creating goals to reduce symptoms. Both of these empirically researched studies have supported the fact that MET with the spirit of MI encourages intrinsic motivation toward change talk and goal planning for success and increasing self – efficacy (Burlew, et. al., 2013).

MI and MET works well for women because it increases the self-efficacy or the confidence level to make decisions and not be concerned of judgment by others which includes the therapist. The motivational enhanced therapy allows the women to focus on their behavior toward the change. In today's society there is still a stigma present when women are in active addiction or make an attempt to begin treatment. The feelings of shame and guilt will actually impede on the woman's ability to ask for help, obtain treatment and actually stay in treatment until completion. There are many different complicating situations that will compromise the woman's ability to ask for help and then complete all the phases of treatment and finally be in the maintenance stage of change.

Trauma Informed Care

Trauma informed care is the therapeutic approach where the counselor incorporates understanding of the impact trauma has on an individual and how it will have negative results on an individuals' well- being along with how the individual responds to the trauma psychologically and neurologically. The therapeutic techniques also examine the cultural impact of the trauma and developing the tools to recover from the trauma that was experienced. In relationship to trauma informed care for women it would be important for the therapist to understand how the trauma has affected the woman socially and psychologically and create strategies that will assist the woman to be empowered.

Experiences of women because of past addiction that interfere with treatment.

The compromising situations are the inability to obtain child care during a regular routine outpatient appointment and this circumstance can then lead to lack of support in the event that the woman has to attend an inpatient facility for longer than 24 or 48 hours. Some women have the support from family and friends or even a significant other to assist with the care of their young children while the woman attempts recovery. This support is vital to give the woman an opportunity to begin recovery and make life style changes. The women who do not have the support from family, friends, or their significant other will usually continue down the path of addiction that may lead to intervention by child protective services. The Child Welfare Information Gateway (2014) states that there is a serious relationship between substance use disorder and child maltreatment; there is a strong correlation between substance use disorders and the negative impact on the child's development. According to the Office of Child and Family Services, the number one reason that there is a break in the relationship between a mother and her child is the separation in the home due to substance use disorders and the inability to have a safe and controlled environment. Evidence has shown that parents that use substances have difficulties in their parenting and the use also disrupts their parenting style. The negative consequences of the parenting style include but are not limited to neglect, lack of impulse control, limited funds to attend to the bare necessities, and the inability to form a healthy bond with their children. The inability to parent effectively compromises children's development and could also endanger their safety and well-being. If this is the case, an intervention is needed to provide adequate supports and care for the mother and the child as well. The supports can be most effective when the woman understands the type of parent she is and how her style will affect the children. It is important for the therapist to discuss the four types of parenting as

reviewed in the chart below and use the strategies discussed earlier such as motivational interviewing to improve the parenting skills. Improving the worldview of the woman as a mother and working on improvements will lower the possibilities of a relapse.

According to Baumrind (1971) she states that parents should not give extreme consequences that resemble punishment consistently nor should the parent be distant from the child. Baumrind, however, states in her research that parents should set boundaries which includes behavior expectations and show affection even when the child is behaving in opposition. Baumrind's (1971) research discovered that there are four types of parenting: authoritative parenting, authoritarian parenting, permissive – indulgent parenting and permissive-uninvolved parenting. The type of parent that the woman experienced from her own mother or caregiver will give an insight as to the mirroring behavior that woman's children have or will experience. Below are the definitions of the four types of parenting that can be discussed in a session.

Authoritative parenting	This is the model parenting because the parents are warm and nurturing which produces children that are independent with high self-esteem and self-efficacy.
Authoritarian Parenting	This style of parenting has rigid rules and base the discipline on punishment whether physical or withdrawing love and affection. The results are the children tend to be more

	conforming to others and are often concerned with pleasing the parent
Permissive – Indulgent Parenting	Overwhelming with warmth toward the child and does not set proper boundaries. The parent therefore does not have control and the children will have difficulty controlling their impulses.
Permissive – Uninvolved Parenting	This style of parenting is uninvolved and displays very limited affection, neglectful, and at times will reject their child. The results are that the children may display deficiencies in their development and ability to communicate. Often these children may show signs of mental health such as depression and oppositional defiant just to name a few.

The most common type of parenting style for substance use disorder parents / mothers is the permissive – uninvolved parenting style which can actually begin during the children’s infancy stage. The permissive – uninvolved parenting can have a lasting effect on their children’s development and impede on their ability to form bonds later in their lives. Another term that is parallel with the permissive –uninvolved parenting style is reactive attachment. Reactive Attachment Disorder (RAD) is important to discuss with women while they are

progressing through recovery. If a woman experienced RAD as a child, as an adult developing relationships are strained, emotionally unattached and complex. The next section will explain RAD and the effect on children to give the manifestation of the behaviors in adulthood and how the behaviors are then transferred to the next generation.

Reactive Attachment Disorder

Reactive attachment disorder is a rare but serious condition in which an infant or young child doesn't establish healthy attachments with parents or caregivers. RAD is a condition found in children who may have received grossly negligent care and do not form a healthy emotional attachment with their primary caregivers -- usually their mothers -- before age 5. Attachment develops when a child is repeatedly soothed, comforted, and cared for, and when the caregiver consistently meets the child's needs. It is through attachment with a loving and protective caregiver that a young child learns to love and trust others, to become aware of others' feelings and needs, to regulate his or her emotions, and to develop healthy relationships and a positive self-image. The absence of emotional warmth during the first few years of life can negatively affect a child's entire future. RAD can affect every aspect of a child's life and development. There are two types of RAD: inhibited and disinhibited.

Common Symptoms of Inhibited RAD Include

Women that are detached from their caregiver as an infant will have difficulty when she has her own children because the ability to be attached has never been felt or a learned behavior (Kumpfer & Fowler, 2007). As a woman that maybe in recovery and has been diagnosed with RAD this complicates the woman's ability to be an efficient parent. As an infant the woman may have been unresponsive or resistant to comforting by a foster parent or by anyone that had

attempted to provide comforting. As an adult the woman would be excessively inhibited and unable to express their emotions. A therapist may often state that the woman is “holding back” emotions. The woman that withholds the emotions of anger, fear and grief, to name a few may express herself through the use of drugs and alcohol instead of talking about how she is feeling. As a result of being diagnosed with RAD the woman may be withdrawn or a mixture of approach and avoidance when dealing with various persons in their life. The women may also avoid various issues by using drugs or alcohol which is an unhealthy approach. As a result, the therapist will need to develop appropriate coping skills that will surround the individual overcoming the patterns of avoiding and withdrawing from various complicated issues.

Common Symptoms with Disinhibited RAD Include

Women with this type of RAD will have difficulty becoming familiar or selective in the choice of attachment figures as children and this carries on into adulthood when the woman becomes a caregiver. RAD occurs when attachment between the woman and her primary caregiver as a child or the woman and her present child. The lack of relationship bonding occurs or is interrupted due to grossly negligent care. This can occur for many reasons, including:

- Persistent disregard of the child's emotional needs for comfort, stimulation, and affection
- Persistent disregard of the child's basic physical needs
- Repeated changes of primary caregivers that prevent formation of stable attachments (for example, frequent changes in foster care)

The woman and the therapist can develop appropriate strategies to identify coping

mechanisms to overcome the RAD diagnosis and to improve the relationship between the woman and her infant or to improve the woman's relationship with others to enhance her recovery.

Therapeutic Approaches for Women

There are various strategies for women that have been proven to be helpful for recovery. Statistics have shown that women who have appropriate coping mechanisms along with proper outlets will have lesser depression and have appropriate coping strategies.

Coping mechanisms have been an important part of a woman's recovery. The importance of having coping skills gives women an opportunity to have solutions to problems. The main reason that women relapse is because they lack solutions to the complex issues that arise in their daily lives. The therapeutic approach can be creating a notebook of various situations that may arise as triggers and then write various solutions to the specific situation. These solutions are known as coping mechanisms. The woman can review the solutions through role playing with the therapist and also with her support system. The more the woman engages with discussing her coping mechanisms the more automatic her responses will be to have a lesser chance to relapse.

The developing of coping mechanisms is important but also the need for support groups is also an important factor for women recovering from substance use disorders. Literature has stated that support from other women is a way to improve the self-efficacy and self-esteem for recovery success (Mann, Hossman, Schaalma, & deVries, 2004). There are various support groups that are helpful to women in recovery such as post-partum depression group, women's group for addiction such as women for sobriety. There are also on-line chat rooms that are helpful for women who have very busy schedules and are not able to leave their homes to attend

a meeting. The need for support groups brings on a camaraderie that allows women to understand they are not alone and will have support to bounce ideas off of and also to encourage change. There are other groups that are useful such as book clubs and theatre clubs that assist the woman to learn to develop appropriate relationships and also relationships that do not revolve around substance use disorders and recovery. If the woman become involved in other groups, she may be assisted in developing hobbies and also enhancing her interests to do activities that do not involve the use of alcohol and/or drugs. One of the main reasons some women have difficulty with returning to previous hobbies that were enjoyed is because the women state these hobbies were done under the influence. As a result, to return to these past hobbies will be a trigger for relapse and an introduction for new hobbies or creative opportunities will need to be introduced by the therapist or the support system.

Finally, some women may be in need of a support system, such as a domestic violence support group, to give the women the confidence to have appropriate solutions to handle their situation without the use of alcohol or drugs as a coping mechanism. Women in need of domestic violence support groups receive proper guidance when they are attempting to make a decision to leave a significant other who is abusive. Statistics have shown that women who stay in abusive relationships usually continue their addiction. The women will stay in active addiction because it actually assists them with coping with their domestic violence situation. The purpose of the support group is to keep the women aware of their decisions and how it will impact their future or their children. The use of domestic violence court is also an important piece since it serves as a mediator for women in domestic violent situations and can also be used as a gait for safety.

The next support group that is important is a parent support group / classes. According to the program EPIC (Every Person Influences Children) groups and / or classes assist parents to learn alternative ways to discipline and also ideas to form a loving environment for children. Groups that educate and provide guidance of this type are necessary since the women may have a diagnosis of RAD and will benefit from learning alternative ways to parent for the success of their children. The need for parent groups is also important to give the women the support needed because the women will have an opportunity to discuss their struggles with other mothers. The need to balance family with the opportunity to stay clean and sober is very important and a worthwhile investment. Since there is an influx in children being referred to the department of social services – child protective services units for children left unattended or improperly cared for, the support groups are essential to a positive home environment and recovery. The topics that can be covered for a parent support group include listening skills, behavior modification skills, and the need to have confidence when parenting.

These groups mentioned above are just some that will enhance the recovery efforts and success of the women that are in the process of recovery. The therapist can create other groups that will be most beneficial to the culture of women who are being counseled. The most salient of groups is that the group creates an empowering environment for the woman to discuss issues and develop solutions or coping skills. The second most salient is that as the woman's ideas and skills are strengthened. It becomes a microcosm of relationships outside of the group itself and increases the success rate of recovery.

Vignette for RAD:

Nichelle is a 30 year old that had an unplanned pregnancy. Nichelle is in early recovery and through the process she became pregnant and was very clear that she was not mentally or emotionally ready to have a child. Nichelle explains to the therapist that she grew up in foster-care because her parents were actively using illegal substances. Nichelle states that her time in foster – care was not loving and she rushed to become independent. Unfortunately, Nichelle began using marijuana heavily to mask her hurt feelings and she soon graduated to using crack cocaine at age 18. Nichelle has had a few months clean, however, she had been using crack cocaine continuously from age 27 to present. Nichelle admitted to the admission nurse that she used during her entire pregnancy. Nichelle’s daughter is born exposed to crack cocaine and experiences Neonatal Abstinence Syndrome acute withdrawal symptoms. After Nichelle’s daughter was in the Neonatal Intensive Care Unit for 9 days Nichelle was able to take her daughter home with frequent visits by a counselor and the Department of Social Service’s Child Protective Services. Nichelle states in session that the daughter cries often and Nichelle does not understand the steps to take to “make the baby better and stop crying.” Nichelle also admits that she does not cuddle with her daughter often. The counselor explains to Nichelle the definition of RAD and how it relates to Nichelle as a child and is now affecting her ability to comfort her daughter. The counselor refers Nichelle to a parenting class and also creates a treatment plan for Nichelle to begin bonding with her daughter daily.

Women, HIV, HCV and Addiction

It's important for social workers to understand that women who are in active use of substances face many medical compromises. In this section you will find information about those medical issues and why it is important to identify them. The medical issues include but are not limited to HIV and hepatitis C (HCV). Women may have exposed themselves to HIV and/or HCV by sharing needles, and also having unprotected sex with partners who are not aware of their own medical HIV and/or HCV status.

Hepatitis C (HCV)

Hepatitis is an inflammation of the liver and can be caused from bacteria, viruses or other toxins. The most common is Hepatitis C which is the result of substance use and a combination of risky behaviors. "Approximately 2.7–3.9 million people are living with HCV in the United States, about half of those infected are women, but most don't know they have hepatitis C" (Brown, 2017). A woman needs to know her status because she can pass the virus to her unborn child. There is a media campaign for women born between 1945 and 1965 to be screened by primary care physicians and / obstetricians – gynecologists. There is other salient information that can alert medical professionals that there is a concern: risky behaviors in the past in relationship to substance use such as needle sharing, high risk sexual behaviors, a history of incarceration and birthmother is HCV positive. Some other concerns are blood transfusions and elevated liver enzymes to name a few.

HCV is treated with medication once it is discovered from the ELISA (enzyme-linked immunosorbent assay) (NIDA, 2017). The medications are monitored and the woman is sent to a specialist who will assess and treat the HCV accordingly. The treatment does, however, begin quickly because otherwise the woman may be at risk for more serious medical issues. The

literature states that more individuals die from HCV than from HBV and HIV combined (NIDA, 2017).

Human Immunodeficiency Virus (HIV)

For counselors who work with women, it is important to discuss HIV status. The counselor can educate the woman on protecting herself and understanding the methods to the transmission of HIV. The woman that is HIV positive has a recovery that is complicated and much support is needed to work on the addiction piece while staying healthy.

According to the Columbia University's Mailman School of Public Health (2012) reviewed statistics for African American women, 25% of those newly diagnosed with HIV were women. Of the newly diagnosed women, 66% were of African descent. The rates of infection actually increase because of poverty and 1 in 48 African American women may become infected with HIV (Prevention.com). These numbers are frightening and prevention may be the only opportunity counselors may have with their female participants to prevent the spread of HIV. Unfortunately, there is an increase of women using opiates and then progressing to heroin. The women are also using the drug intravenously and this increases the spread of HIV. There is also an increase of HIV for women because of the inability to access treatment and / or prevention. The means of unstable housing and lack of proper insurance are some reasons women do not receive or follow through with adequate services. Some women may trade sex for living arrangements which raises the possibility of transmitting the disease.

Effect on the Family

Since HIV has affected women at alarming rates it is important to keep in mind the role that women have in our society. Women are heads of their households and are depended on in

various capacities. According to Joe (2015) the stressors on the woman as the disease of HIV progresses is debilitating to the family and calls for restructuring of the family and for the woman. As a result, it is vital that education happens frequently with the family members that may be involved. This education includes assisting with medications and the progression of the disease.

Pequegnat and Bray (2012) and Joe (2015) both agree that interventions such as education in the areas of safe sex practices, increased communication between family, and education regarding high risk behaviors can be used during substance abuse counseling sessions. The other negative impact on family is if the woman decides to continue using drugs / alcohol and has HIV. This can lead to deteriorating health which can also negatively impact the family structure. Illangaskare, Burke, Chander and Gielen (2014) along with Campbell and Lewandowski (1997), state that the prevalence of depression disorder and HIV positive women is significantly higher than women not diagnosed with depression. Along with the mental health diagnosis the women may also suffer from anxiety and post – traumatic stress disorder and have a higher suicide risk than their counterpart. Illangasekare et. al (2014) noted that African American women benefited from and depended upon an informed support system and were less likely to attend traditional mental health services. Their study also discovered that the depressive symptoms are a gateway to increased use of substances which then returns to a vicious cycle of addiction.

Substance Abuse and HIV

One might think that women diagnosed with HIV and depression use or abuse a substance to handle their mental health condition. However, according to Barrose and Sandelowski (2004), HIV was a motivator for women to become clean and sober. Previous research from Bell (1997) and Santacroce, Deatricks, and Ledlie (2002) showed that women reduced / discontinued their use because of their diagnosis. The women's family responsibilities were a motivator to be healthy and follow the medical recommendations.

HIV Medications

HIV medications were tested on males that tested positive. The use of the medication varies upon the white cell count along with the weight and the medical condition of women. Since women's bodies are more complex and may come with a variety of medical conditions the medications may not begin to show effects against the disease until much later. As a result, the women may begin to feel that the medication is not being effective and then depression sets in and relapse at this point may be inevitable. Once the woman begins to use drugs or alcohol to mask the depression, the administration of the HIV medications are taken less frequently which then will cause more medical complications as well as compromise the woman's health. It is also important for the woman to schedule when the medications can be administered.

Future Thoughts for Women

It is important for women to have addiction treatment that is specialized to their lifestyle, and the multifaceted roles that are acted out daily. There is a need for research to develop therapeutic strategies that focus on the stressors women experience. Along with the research there is a need to develop coping strategies in relationship to the woman's childhood to gain self-

insight on generational decisions and generational addiction. There is a need for treatment to include the component of medical examinations with a focus on HIV and HCV. Finally, there is a need for women to have a support system on many different levels to increase the length of sobriety.

Conclusion

Once a woman is referred to treatment it is important for the therapist to consider the following items: past or current traumatic events, family history especially in the area of bonding and finally the woman's desire to be in recovery and the possible solutions / strategies to obtain sobriety. Once the therapist has this information, the therapist is able to identify the weak areas and assist the women to strengthen their recovery process.

Woman diagnosed with alcohol / substance use disorder whether mild, moderate or severe have a plethora of complications on the progressive road to recovery. The clinician working with the woman must take into consideration other life events that may complicate the recovery or simply stop the recovery from existing. The counselor / therapist must take into account the life the woman has outside of the therapeutic walls and discover the events that have created the person that is now seeking treatment. Some experiences to consider are but are not limited to exploring the childhood and the relationship the woman had or continues to have with the caregiver. The exploration of traumatic events is necessary since the events may impede the recovery process because the woman has not desensitized her emotions toward the event and the event may be a lasting trigger. The counselor should also identify if the woman has the responsibility as a parent and where she may see herself as an influence or role model for her children. The lack of parenting skills may also be a challenge and the means of coping with this incompetence is the continuation of using alcohol or other substances. It is important that the

counselor not only addresses the addiction, but also these other concerns mentioned during this course to give the woman the best chance of recovery and coping with life's challenges.

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