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SPECIAL TOPICS

Interview on Treatment for Women with Substance Use Disorder, Mental Health Disorders, and Histories of Trauma: An Interview with Francine Feinberg, PsyD, LCSW

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During the past several decades, the substance abuse treatment field has recognized that women often develop and experience substance use disorders differently than men. In addition, trauma, often perpetrated by someone known and trusted, and mental health diagnoses are also common among women with substance use disorders (CSAT, 2009; Najavits, 2009). Although efforts, including national efforts, have been made to promote treatment principles that are gender responsive (CSAT, 2009), treatment tends to focus on individuality and responsibility; yet, women often define themselves through their social relationships and obligations to others (CSAT, 2009; Salter & Breckenridge, 2014).

To look more closely at the evolution and present-day status of substance abuse treatment for women with cooccurring mental health disorders and histories of trauma, we interviewed Dr. Francine Feinberg. For almost 30 years, Dr. Feinberg was the Executive Director of Meta House, a substance use disorder treatment organization in Milwaukee, WI, including both

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residential and outpatient treatment for women, their children, and their families. Dr. Feinberg talks about her perspectives and long-term experience in working with this special population.

Berger: The substance abuse treatment field has evolved over the past 30 plus years to recognize that treatment was not meeting the needs of women. From your perspective, how did this evolution take place?

Feinberg: Treatment for substance abuse originally grew out of the AA self-help movement. Since the vast majority of people attending these programs were White men, treatment evolved based on their perceived needs. As more women started to enter the field of substance abuse treatment in the 1970s and 1980s, we start to see literature that challenges both the stereotype of the substance-dependent woman and the approaches that are taken for their treatment. At about the same time, the National Institute on Drug Abuse (NIDA) began to do research to better understand both the psychological and physiological gender differences of drug and alcohol use, which has also contributed to our understanding and approaches to treatment. One of the greatest contributions to the field came from the Stone Center at Wellesley College with the introduction of the self–in-relation theory, now called the relational-cultural theory of the psychology of women. This theory shifts the thinking from the idea that the goal of healthy human maturation is the ability to individuate or separate from others, to a "relational self" in which women's sense of self is organized around making and maintaining affiliations with others. So rather than trying to be "independent or self-made," this theory revolves around the idea that connections to others are fundamental to the psychological growth and the healing process for women. This theory helps us describe how women behave, why they behave that way, and gives us principles to help us define what to do in treatment. Of course, this theory has to be understood within the culture of each woman's life. Another major contribution to the field is the acknowledgment of the relationship between the exposure to traumatic events and behavioral health disorders. Women with substance use disorders have very high rates of sexual and physical abuse, adding an important and defining dynamic to the treatment process.

Berger: What are some of the unique risk factors and presenting issues of women with substance use disorder, mental health disorder(s), and histories of trauma?

Feinberg: When I first started at Meta House in the early 1980s, I was both the executive director and a counselor. Prior to coming to Meta House, my professional interests were focused on women, although I did have some experience working with men who abused substances and their spouses or

partners. All of this is to say that I did have experience working with women and had at least a basic understanding of substance abuse. But, listening to the women at Meta House was an eye opener. I was shocked to hear about their devastating pasts and the complications of their lives. At the time, I did not know that this was the norm for women that abused substances. We now know that women that abuse substances do have many, many risk factors and face significant challenges in their lives. Compared to men, women have much more significant dysfunction in their childhood families. As I said, the women are likely to have experienced interpersonal trauma such as childhood sexual abuse, but we also find early separation from parents or parental deprivation, rejection, and violence in their family of origin. They are also more likely than men to have parents who are addicted. Chances are high that they have been victimized as adults, they are more likely than men to be poor, have fewer job opportunities, and be the primary or only person caring for children or other family members. They also tend to be juggling multiple roles with little support from partners or family members. Because of the neglect and the impact of substances on their bodies, many of the women need medical attention for serious health-related problems and they are much more likely than men to have cooccurring, mental health disorders. They are often involved in multiple systems such as child welfare, Temporary Assistance for Needy Families (TANF), criminal justice, each of which has multiple requirements for her to meet. About 70% of women entering treatment are mothers, most of whom will have children in their care and the children may be exhibiting symptoms that stem from maternal substance abuse, making their care difficult and stressful. Needless to say, when women enter treatment they bring a host of issues with them in addition to the abuse of substances.

Berger: The substance abuse treatment field has evolved more recently to recognize the need for simultaneous treatment of substance use disorder, and in particular, trauma. How has this affected women's treatment?

Feinberg: The current information about appropriate treatment for women is defined into two categories in what I like to think about as the philosophy that drives the interpersonal and organizational style, and the array of actual services that are provided. In substance abuse treatment, the interpersonal and organizational style has tended to revolve around a top-down relationship with the provider who is seen as the expert and the client who is seen as someone that is broken and in need of fixing. Relying on the relational-cultural theory, the belief that women will heal through the development of healthy mutual relationships, and what we now know are the best practices for working with people who have experienced trauma, a very different approach is taken. The approach is strength-based, empowering, focused on safety and for all intents and purposes, identical to what we now call a trauma-

informed treatment approach. As for the actual treatment of the trauma, which we refer to as trauma specific, there are differing opinions about that. Some believe that while in treatment for substance use, and especially the early stages, it is not necessary and may actually be harmful to directly encourage the active process of bringing up the trauma memories and processing the past. And indeed, traumatic memories can be extremely upsetting, especially when adequate coping skills to control the feelings and impulses have not yet been learned. My personal belief is that, at a minimum, while in the early stages of treatment, the women should be provided an opportunity to learn from a cognitive-behavioral coping skills model that focuses on the present. There are several very good manuals to provide psychoeducation about how to decrease symptoms using coping skills. I think that if a woman wants, feels ready, and has a therapist experienced in helping her address the actual trauma, that would be appropriate as well. In addition, because violence is so pervasive in the lives of these women, as a matter of course, services should always include the recognition of and how to prevent further violence in their lives.

Berger: For women who are pregnant or parenting, how is their role of caregiver addressed in treatment? For example, what is family-centered treatment?

Feinberg: Let me start by talking about family-centered treatment. The purpose of family-centered treatment is to rebuild the relationships which will, in turn, support women and their recovery. That means that treatment is focused on the relationships women have in their day-to-day lives such as children and family members, but it also includes the relationships they have with the staff and other women in the treatment program. Family-centered treatment is always strength-based and trauma-informed, which defines the core beliefs that determine the kind of relationships that will exist among staff and clients. Being family-centered also defines the services that will be provided and who gets those services. For example, children, family members, and others who are important in the woman's life may be very involved in the treatment process and actually receive services themselves. The fact that you are even asking me about a woman's role as a parent and how it is addressed in treatment is a testament to how far we have come in raising awareness about gender differences and the needs to be addressed in treatment for women. There are very good reasons why it is so important to address parenting in the context of treatment. Recovery from substance abuse is a process that ultimately allows people to find purpose and meaning in life. Since women highly value and grow through their relationships, it should be no surprise that a mother's recovery needs revolve around the role that most defines her sense of self and actually absorbs her daily life—being a mother. And, despite the stereotype, even though they may not be able to demonstrate it, these women are extremely concerned about the well-being of their

children. At Meta House, we always asked women why they came to us. "What is it that you want?" Almost every mother said, "I want to be a good mother." And indeed, there is also some evidence that indicates that maternal reflective functioning or the ability to empathize and parent does foster a decrease in substance abuse and supports sobriety. In other words, if treatment can help a woman be a good mother, the thing that is so important to her, her sense of self and purpose is enhanced and she is more likely to stay sober. How much and how children and other family members actually get involved in the treatment process will vary based on what an agency is capable of doing. There is a Substance Abuse and Mental Health Services Administration (SAMHSA) publication called *Family-Centered Treatment for Women with Substance Use Disorders: History, Key Elements and Challenges* (Werner, Young, Dennis, & Amatetti, 2007) that defines the various levels of commitment a program can make to family-centered treatment. This ranges from treatment that focuses on the woman with some family involvement to treatment that includes the development of treatment plans for children and any other family members involved in her life. The actual services provided in family-centered treatment can be categorized as those that are just for the women, those that are for the children, those that address the mother–child relationship, and those that are specifically for other family members.

Berger: How are the emotional, physical, and developmental needs of children addressed as part of the treatment process, and what services are they offered?

Feinberg: Programs that are equipped to serve children, at minimum, can provide screenings for the children. Some can go on to provide the needed assessments and the actual treatment required. Others may offer some services in house and make referrals for other things such as physical, occupational, and speech therapy. Some agencies work with the children's schools to assure that they are getting the services needed and that these services are integrated and not duplicated. Other services for children might include pediatric care, social services, education and recreation, substance abuse prevention, and so on. The mothers in treatment receive services to address the mother–child relationship such as trauma-informed training in parenting, nurturing, and basic life skills. Perhaps the strongest contribution that bringing children into the family-centered treatment program can offer is the opportunity to work with the mothers while they are with their children. This can take the form of formal mother–child therapy or simply be an opportunity for staff to be with the mothers as the mothers put into action what they are learning in their nurturing and parenting classes.

Berger: Given that women who are pregnant or parenting in substance use disorder treatment are often involved in the child welfare or criminal justice systems, how does such involvement impact their treatment?

Feinberg: Women and their families are likely to be involved in multiple systems. Each system has its own goals, timelines, language, and expectations for the women. Because there is little to no communication among these agencies and their workers, women and their families are faced with multiple demands that pose not only logistical issues, but conflictual and redundant burdens. One of the services that family-centered treatment agencies provide is the structure for the coordination and communication among all these agencies. These agencies can build relationships with other systems so that there is an awareness about not only the required demands of each agency on the family, but also the resources each agency has to offer. This process then allows the woman and her family to be in compliance with the plans of each agency in a manner that is realistically manageable. The family-centered treatment program can also educate these systems when workers do not have a good understanding of substance abuse and trauma and this also helps the workers realize that if treatment is successful, the woman likely is to be successful in their system as well.

Berger: What are some of the challenges involved in implementing and delivering services to women and their families for the treatment of substance use disorder, mental health disorder(s), and histories of trauma?

Feinberg: This is not easy. A substantial commitment is needed to implement and maintain these programs. There are fiscal, administrative, and organizational implications for agencies that choose to provide treatment programs that are appropriate to women. To be family-centered and gender-appropriate for women means that the agency will need to be more complex, especially if children are present in the treatment process. Each family will be assisted by a team of people made up of many disciplines that must operate as one. Every member of the team must share a common philosophy about the interpersonal and organizational style that is used, and the staff that has expertise and primary responsibility for the adults and those that have expertise and primary responsibility for the children must be aligned. As you can imagine, bringing children into a program and involving other family members changes the dynamics of treatment. It forces staff to constantly balance the need to empower and respect the mother's authority in her relationships with her children and others in her life, and at the same time, they must help improve parenting, assure the safety of the children, and help her improve her interactions with others. In other words, the treatment process is no longer just a dynamic interaction between the client and her therapist. The treatment process is a dynamic interaction with staff, children, and every other person who the woman defines as her family. One of the biggest challenges faced by these programs is fiscal. Clearly, these programs do not fit the traditional model followed by most payers of services. Although it is possible to bill for

some of the services, in reality, the majority of services will not be covered by traditional means. The good news is that because so many people and so many different services are being provided, there are usually other ways to get these costs covered. This means that programs must know the funding opportunities, become very creative in their approach to funding, and have an accounting system that can keep track of multiple funding sources.

Berger: From your perspective, what are the next steps for developing and sustaining treatment approaches that specifically address the complex treatment needs of women with substance use disorder, mental health disorder (s), and histories of trauma, and what is your current involvement in the Wisconsin-based project called the Women of Worth program?

Feinberg: SAMHSA has, and continues to, take the lead on this issue. They offer grants for pregnant and postpartum women, and parenting programs for women and offer a significant amount of information about the knowledge in the field. They are formally developing leadership around the country through their Women's Addiction Services Leadership Institute and have developed several publications that are directly or indirectly addressing the issue of women and substance abuse. I would encourage anyone, including social workers, who is interested to look at their Web site and search not only for information on women and girls, but also for trauma, cooccurring disorders, homelessness, and child welfare. They are currently presenting a webinar called "Women Matter" for which I had the privilege of being one of the opening speakers. Their previous webinar, called "Girls Matter," can be seen on their Web site. This is such an important issue for both the current and future generations. The education about substance abuse, trauma, and what it takes to break the cycle for women must continue so that the public and the funders are aware of the specific needs, the cost of providing this service, and the cost to society of not providing this service. I am happy to say that programs for women are popping up around the country despite the funding intricacies. I am currently involved as a consultant in the development of a family-centered treatment program in Racine, WI, called Women of Worth (WOW). The approach taken for this project is built on a community collaborative that includes the involvement of many different partners, all of whom bring their expertise and resources. Because so much is involved in providing family-centered treatment this, program chose to develop a model that is built on the buy-in of many different agencies in an attempt to make the program more sustainable. There has been a tremendous commitment to the philosophy of working with women with substance use disorders and much of the programming is currently in operation. We are still developing and refining the program, but so far the outcomes and feedback from the women have been very good.

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