Evaluating, Treating and Monitoring the Female DUI Offender.

William L. White and Maya Hennessey

The number of females arrested and re-arrested for driving under the influence of alcohol or other drugs has increased in the past two decades. Increased female representation within those arrested for driving under the influence (DUI) of alcohol or other drugs suggests the need for more nuanced approaches to their evaluation, treatment, sentencing and supervision. The purpose of this short monograph is to briefly review what is known about: 1) the prevalence of female drinking and driving, 2) the profile of the female DUI offender, 3) gender-specific patterns of alcohol and drug dependency, 4) special approaches to the treatment of the female DUI offender, and 5) patterns of long-term recovery for women. The monograph includes recommendations drawn from the scientific literature and the authors’ experience treating addicted women and evaluating gender-specific treatment programs.

Women and the State of Alcohol and Drug Studies

The number and quality of studies of alcohol- and drug-related problems, addiction and recovery among American women have significantly increased over the past two decades. In our review of the scientific literature on substance-impaired driving among women, we found that that majority of these studies had been published since 1990 and that the methodological rigor of these studies had significantly increased since 2000. These studies are generating findings with significant implications for the design of intervention programs for females arrested for driving under the influence (DUI). For years, female patterns of DUI were obscured in the much larger sea of male offenders. Science has begun to open a window on this previously invisible population of women and point the direction to more effective approaches to evaluation, treatment, sentencing and supervision.

Consumption Patterns

The best source of data available on adult patterns of alcohol, tobacco and other drug use is the regular National Survey on Drug Use & Health conducted by the Substance Abuse and Mental Health Service Administration. The most recent of these
surveys (2003) revealed that 74.5 million (61%) females aged 12 or older and 30.0 million (70%) males aged 12 or older consumed alcohol during the past year. This same survey revealed that 15.2 million (12%) females and 19.8 million (17%) males had used an illicit drug during the past year. Data on alcohol and other drug consumption patterns of younger females is available through the annual Monitoring the Future Survey sponsored by the National Institute on Drug Abuse. 52.3% of female twelfth graders report consumption of alcohol in the past 30 days and 24.4% of females (versus 33% for males) report having consumed 5 or more drinks in a row in the past two weeks. In 1975, the spread between males and females on this last figure was 23 percentage points, reflecting the subsequent leveling of differences in alcohol consumption patterns between women and men. Similar trends are occurring for illicit drug use with 30.1% of female high school seniors (compared to 34.3% of male high school seniors) report having consumed an illicit drug in the past twelve months (Johnston, 2006). Older women are more likely than younger women to consume only alcohol or to consume alcohol and prescription drugs. Younger women are more likely to combine alcohol and illicit drugs (Lex, 1994).

Changes in psychoactive drug consumption by women, particularly young women, have been linked to broader changes in gender roles and to promotional targeting of women by the alcohol, tobacco and pharmaceutical industries special products and appeals linking these products to beauty, wealth, social popularity, sophistication, sexuality and, perhaps most offensively, with liberation ("You've come a long way, Baby!") (White & Kilbourne, 2006). Increases in DUI arrests for women reflect both changes in social norms about women and alcohol, but also the fact that more women are driving and driving more frequently and more miles (Popkin, 1991). It is interesting to note that increased substance use among women and increased driving does not convert into risky driving decisions to the degree seen in men. The greater risk for men for DUI and DUI recidivism may well be linking to their increased propensity for impulsivity, risk-taking and aggression than differences in substance consumption (Elliott, Shope, Raghunathan & Waller, 2006). Females seem to drive more cautiously with or without alcohol in their systems (Zador, Krawchuk, & Voas, 2000).

**DUI Prevalence Rates among Women**

In the National Survey on Drug Use and Health, 11.4% of women aged 21 or over (compared to 22% of men aged 21 or over) reported driving under the influence of alcohol or other drugs in the past year (NSDUH Report, July 1, 2005). However, “as consumption increases, the male-female difference decreases and, in the heaviest drinking group, the rate of driving while intoxicated is almost as high among women as it is for men” (Johnson, Gruenwald & Treno, 1998). While the total volume of female DUI arrest rates is far lower than those for men, DUI arrests constitute the largest category of alcohol-related crimes that bring women into contact with the criminal justice system (Parks, Nochajski, Wieczorek & Miller 1996). As such, these arrests events constitute a significant opportunity to intervene with women who are experiencing significant alcohol problems. Yet, in Illinois, so few women are referred to women specific treatment.

Looking at the specific issue of drug-impaired driving, 3% of females age 12 or older (compared to 6% of males) report driving under the influence of a drug (NSDUH Report, September 16, 2003).
The gender discrepancy in these rates is further indicated in fatal crash data revealing that male drivers involved in fatal motor vehicle crashes are almost twice as likely as female drivers to be intoxicated with a blood alcohol concentration (BAC) of 0.08% or greater (NHTSA 2004b), however the percentage of male drivers in alcohol-related fatal crashes has decreased while female drivers in such crashes have increased (Waller & Blow, 1995; Abdel-Aty & Abdelwahab, 2000). Several studies have also concluded that females are at greater risk of involvement in fatal crashes at lower levels of intoxication than are males (Waller & Blow, 1995).

In Illinois, 17% of those arrested for DUI are women (DUI Fact Book, 2004), but DUI arrest for women have risen both nationally and in Illinois in recent decades (Parks, Nochasjski, Wieczorek & Millerm 1996).

Studies of the DUI recidivist report that female DUI offenders are less likely to be re-arrested than are male DUI offenders. In a follow-up study of 3,425 DUI offenders, Wells-Parker and colleagues (1991) found males twice as likely to recidivate as females. Most studies of DUI recidivists conclude that 90-95% of recidivists are male (White & Gasperin, in press).

Profile of Female DUI Offenders

Only a small number of studies have focused specifically on the profile of the female DUI offender, and even fewer that profile the female DUI recidivist. Major findings from existing studies reveal that the female DUI offender is likely to:

- Be unmarried, separated or divorced (Wells-Parker, et al, 1991; Chang, Lapham & Barton, 1996)
- Unemployed and seeking employment (Wells-Parker, et al, 1991)
- Be drawn from wide age span (20-50) (Wells-Parker, et al, 1991)
- Be arrested secondary to a vehicular crash rather than for erratic driving (Waller & Blow, 1995).

Compared to young male DUI offenders, younger female DUI offenders are likely to exhibit greater alcohol, marijuana and tobacco use and report more strained relationships with their parents and parental disapproval of their friends (Farrow & Brissing, 1990).

Clinical classification differences exist between men and women arrested for DUI. Wells-Parker and colleagues (1991) found that 47.3% of female DUI offenders were classified as “high-problem-risk” compared to 57% of male DUI offenders. These figures underreport alcohol problems for both men and women due reliance on self-reported information whose validity is significantly compromised by fear of legal repercussions. A five-year follow-up study of convicted DUI offenders revealed that 85% of the female offenders (compared to 91% of male offenders) met lifetime criteria for alcohol abuse or alcohol dependence, and that 32% of female offenders (compared to 38% of male offenders) met lifetime criteria for a non-alcohol related substance use disorder (Lapham, Smith, C’d’e Baca, Chang, Skipper, Baum, & Hunt, 2001). A study of 1,105 DUI offenders in New Mexico found that of those with alcohol use disorders, 32% of females (compared to 38% of males) also had a drug use disorder and that 50% of women (compared to 33% of men) had an additional psychiatric diagnosis (Lapham, Smith, C’d’eBaca, Chang,
Skipper, Baum & Hunt, 2001). These studies underscore the high percentage of female DUI offenders that are experiencing alcohol problems and the severity and complexity of those problems.

Few studies have compared the profiles of the male and female DUI recidivist. The best data available suggests the following:

- Male and female DUI recidivists are similar in ethnicity, levels of education, BAC at time of arrest, and lifetime substance use.
- Female recidivists reported higher rates of parental alcohol problems.
- Female recidivists reported higher rates of having hit or thrown something at their spouses (Lampham, Skipper, Hunt & Change, 2000).
- Younger female recidivists are more likely to share traits of rebellion and anti-social behavior similar to male DUI recidivists (Moore, 1994).
- Female recidivists have high rates of alcohol dependence and high rates of past year use of other psychotropic drugs (Lex, Sholar, Bower & Mendelsoln, 1991)

Given the limited number of studies available on female DUI offenders, we have highlighted below some of the broader studies on addiction, treatment and recovery among American women that have implications for the evaluation, treatment, sentencing and supervision of female DUI offenders.

**Female Alcohol/Drug Physiology**

There are pronounced differences between men and women related to the metabolism and physical effects of alcohol. Here are the key differences:

**Metabolism:** Women reach higher blood alcohol concentrations and become more impaired than men after drinking the same amounts of alcohol. This is related to the fact that women have lower mean body water volume than men (creating higher alcohol concentrations) and greater difficulties metabolizing alcohol (resulting from lower levels of the gastric alcohol dehydrogenase required in the metabolism of alcohol) (Lex, 1991; Blume, 1992; NIAAA, 1999).

**Effect of Menstruation:** Blood alcohol levels for women vary across phases of the menstrual cycle. Women report becoming most intoxicated before onset of menstrual flow and least intoxicated immediately after onset. Such variation is minimized for women taking oral contraceptives. The onset and intensity of binge drinking has also been linked to pre-menstrual distress (Russell and Czarnecki, 1986).

**Alcohol-related Medical Problems:** Women develop alcohol-related physical problems faster than do men. Women develop alcohol-related liver disease (alcoholic hepatitis with and without cirrhosis), hypertension, anemia, gastrointestinal hemorrhage, and ulcers after shorter periods of drinking and at lower levels of alcohol intake than men. The risks for alcoholic cirrhosis and cancers of the head and neck are elevated for women who consume more than 2-5 drinks per day (Wilsnack, 1984; Gearhart, 1991; Gomberg, 1993). The medical risks of alcohol consumption extend beyond the woman herself. Fetal Alcohol Syndrome / Fetal Alcohol Effect (FAS/FAE) is a preventable form of developmental disability caused by excessive alcohol consumption during pregnancy.
Alcohol-related Mortality Rates: Alcohol dependent women have higher (50-100%) mortality rates than either non-alcoholic women or alcoholic men (Hill, 1986; Gomberg and Nirenberg, 1993). Primary causes of death for alcohol dependent women include diseases of the digestive and circulatory systems, accidents (particularly alcohol-sedative combinations), suicide and death by violence (Lex, 1991).

Incidence and Risk of Substance Use Disorders in Women

The Substance Abuse and Mental Health Service Administration’s National Survey on Drug Use & Health defines substance dependence or abuse using criteria specified in the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*. These criteria include such symptoms as recurrent drug or alcohol use resulting in physical danger, trouble with the law due to drug or alcohol use, increased tolerance to drugs or alcohol, and giving up or reducing other important activities in favor of drug or alcohol use. Based on the latest of these surveys, 5.9% of women aged 18 or older met criteria for abuse of or dependence on alcohol or an illicit drug in the past year. 15.7% of females aged 18-25 and 26.3% of males aged 18 to 25 met criteria for either dependence or abuse. Among those aged 26 or older, males were twice as likely as females to be dependent on or abusing alcohol or an illicit drug. The rate of substance dependence or abuse for persons age 50 or older was 4.9% for males and 1.5% for females (SAMHSA, 2005).

The higher rates of alcohol dependence for males was long thought to be based on greater genetic vulnerability for alcoholism among men, but recent studies of the heritability of alcoholism have concluded that a substantial (over 50%) of the risk of female alcoholism is genetically influenced (Kendler, et al., 1992; NIAAA, 1999). Many addicted women admitted to addiction treatment, particularly those entering through a DUI referral mechanism, present with multiple etiological factors: genetic risks related to intergenerational family histories of alcoholism, a history of physical and sexual abuse; a history of emotional deprivation, and anxiety and depression that make frequent mood alteration desirable; and involvement in intimate relationships and social groups that promote excessive drinking.

Onset of AOD Problems

Compared to men, the onset of alcohol and other drug problems in women occurs at a later age and is more likely to be associated with a particular life event (e.g., childbirth, breast removal, hysterectomy, family problems, divorce, physical or sexual assault, or the loss of a parent, spouse, or child through death (White, Woll & Webber, 2003; Beckman and Amaro, 1986).

Female Patterns of Substance Dependence

There are many clinically relevant gender differences in substance dependence. The course of alcohol and drug dependence in women is different than men in its symptomatology and is marked by a faster progression—the latter often referred to as “telescoping” (Smith and Cloninger, 1981). Such accelerated effects were first noted in women addicted to alcohol (Corrigan, 1980; Hesslebrock, et al., 1985; Stabenau, 1984).
These early studies confirmed that women become physically addicted to alcohol more rapidly than men and with less volume of alcohol consumed (Spiegel, 1986). Later studies also discovered that women developed heroin addiction more quickly than men (Hser, et al., 1990). Studies of men and women addicted to cocaine reported women had earlier onset of use, higher rates of daily use, higher risk methods of ingestion (smoking or intravenous), more concurrent alcohol use, and an earlier age of entry into treatment (Griffin et al., 1989; Wechsberg, et al., 1998; McCance-Katz, et al., 1999).

In spite of the severe medical consequences of alcoholism in women, women alcoholics consume less alcohol than do male alcoholics and report less daily drinking and binge drinking (Blume, 1992). The phases of alcoholism are less distinct (Lisansky, 1957) and the symptoms and stages of alcoholism differ somewhat for women. Beginning with the work of James (1975), studies have documented that several early stage symptoms of alcoholism in men constitute late stage symptoms of alcoholism in women. For example men begin to choose substances over relationships during early stages of problem development while women cling to relationships well into the later stages of dependence.

Addicted women are more likely than men to be using other drugs in conjunction with beverage alcohol. They frequently present patterns of multiple concurrent and/or sequential drug use (Edwards, 1985; Celentano and McQueen, 1984). Multiple drug use places women at a higher risk for cross-addiction, toxic drug interactions and fatal overdoses.

Differences between male and female substance use patterns have been diminishing in recent years (Green, 2006).

**Ethnic/Gender Differences**

White, Woll & Webber (2003) reviewed the characteristics and consequences of addiction across ethnic groups and found substantial differences. African-American women tend to be clustered at the extremes of abstinence and heavy drinking, with more African American women totally abstaining than White women (Gary and Gary, 1985). Mexican-American women abstain from alcohol or drink moderately. While the pattern of alcohol abstinence has been consistently reported for immigrant Mexican American women, there are more recent reports of moderate and heavy drinking by Mexican-American women born in the U.S. (Caetano, 1985; Gilbert, 1987). Native American women experience the highest proportion of alcohol deaths. The alcoholic cirrhosis death rate for Native American women, ages 15-34, is 36 times the rate for White women; the rate for African-American women is 6 times the rate for White women (Malin, et al., 1978). The addictions literature is almost completely silent on the drug consumption patterns and problems of Asian-American women.

**Addiction and Psychiatric Illness**

Where addicted men are more likely to experience co-morbid personality disorders, addicted women are more likely to experience co-morbid affective disorders (Wilsnack, Wilsnack and Klassen, 1984). Addicted women are twice as likely to report major depression than addicted men (Wechsberg, et al., 1994) raising the potential that
some women may self-medicate affective disorders with alcohol and other drugs. The co-
occurance of eating disorders (particularly bulimia) and substance use disorders has also
been noted in the clinical literature (Katzman, et al., 1991; Holderness, et al., 1994). A
1996 NIMH-funded study of women detainees in Cook County Jail found that over 80%
of the 1272 detainees met criteria for one or more lifetime psychiatric disorders. (Arch
Gen Psychiatry/Vol 53).

Victimization as a Risk Factor

The relationship between childhood sexual abuse and/or subsequent sexual
trauma and the onset and course of alcohol and other drug problems is a complex one.
Key research and clinical findings include the following:

- Women with substance use disorders report higher rates of childhood sexual
  abuse compared to non-addicted women (67 percent compared to 28 percent)
  (Blume, 1992; Forth-Finnegan, 1991, 1984; Rachel, 1985; Covington, 1986), and
  reports of childhood sexual abuse among addicted women seeking treatment
  range between 75-90 percent (Rohsenow, Corbett and Devine, 1988; Zweben,
  1996).
- The link between developmental victimization and the subsequent development of
  substance use disorders may be intensified with the presence of key traumagenic
  factors, e.g., early onset of abuse, long duration of abuse, victimization by family
  members, multiple perpetrators, and failure to protect following early disclosure
  (White, Woll & Webber, 2003).
- Addicted women often present patterns of serial victimization—childhood sexual
  abuse followed by later episodes of physical and/or sexual assault (Miller, et al.,
  1989).
- Addicted women with histories of sexual victimization have a higher incidence of
  health problems and health care utilization than do addicted women without such
  histories (Liebbschultz, Mulvey and Samet, 1997).
- The sexual victimization of addicted women is often clinically nested within a larger
  cluster of problems, including feelings of depression, worthlessness, and
  powerlessness; suicidal thoughts; toxic, abusive intimate relationships, impaired
  mother-child relationships, and environmental chaos (Gomberg, 1993).
- The sexual abuse of addicted women may contribute to many of the clinical issues
  often noted in women’s treatment programs: fear and distrust, shame and guilt,
  feelings of unworthiness; conflict about sex role identity; self-doubts about
  adequacy as a woman; and sexual dysfunction (Wilsnack, 1973; Kirkpatrick,
  1986).
- The preponderance of addicted women with a history of physical and sexual abuse
  suggests by itself the need for special approaches to their treatment (Skorine &
  Kovach, 1986).

It was long thought that a sexual abuse history was predictive of poorer treatment
outcome, but this assumption is being challenged by recent studies. These studies note
that women with sexual abuse histories report numerous problems (depression, anxiety,
low self-esteem, low decision-making confidence) at treatment admission and at follow-up, but that they are more likely than women without such histories to consume less illicit drugs following treatment, be in counseling for psychological problems and to be taking psychotropic medications under the direction of a physician (Bartholomey, Courtney, Rowan-Szal & Simpson, 2005).

Obstacles to Treatment

Women encounter greater obstacles to initiating and completing treatment for a substance use disorder than do men (Green, 2006). These obstacles include intense social stigma attached to addicted women (particularly addicted mothers), female socialization (e.g., learned helplessness, passivity), multiple role responsibilities, inadequate insurance and financial resources, fear of loss of custody of children and legal punishment (for pregnant, addicted mothers), and lack of child care, transportation and sober housing (NIAAA, 1983, Gomberg, 1988, Schliebner, 1994, Burman, 1992, Finkelstein, 1994)

Treatment Entry Decisions

There is growing evidence for gender-specific factors related to the initiation of recovery (e.g., pregnancy) and in obstacles to successful recovery (e.g., intimate involvement with an addicted husband or partner) (Anglin, et al., 1987). The entry of addicted women into treatment is associated with 1) perception of alcohol or drugs as a problem, 2) life events (consequences) that precipitate a crisis and need for change, 3) the anticipation or experience of hope that treatment can produce positive change, 4) the perception that the treatment agency has programs that can respond to her special needs and the needs of her family, and 5) a social network that supports entry and continued involvement in treatment (Thom, 1984). Waldorf (1983) found women separating from addicted husbands/paramours (often subsequent to their arrest) as a major factor in initiation of natural recovery in addicted women. Similarly, Wilsnack and her colleagues (1991) found divorce or separation associated with improved post-treatment outcomes among treated, married women (Wilsnak, et al., 1991).

Admissions of women to treatment have until recently been linked to health or family concerns (pregnancy, effect of use on children) than the occupational or legal issues that tend to bring men to treatment (Blume, 1992; Burmann 1997). Pregnancy and/or concern about parental adequacy are major motivators for women seeking entry into addiction treatment (Rosenbaum and Murphy, 1990l Chen & Kandel, 1998), but the increased involvement of women in the criminal justice system has sparked a dramatic increase in women, particularly younger women, entering addiction treatment.

The use of indigenous outreach workers is effective in engaging women in addiction treatment who have previously resisted seeking out such services (Groos and Brown, 1993; White, Woll & Webber, 2003).
Female Treatment Admissions

Females made up 30% (565,400) of the 1.9 million addiction treatment admissions in the United States in 2002. Females admissions were an average of 33 years of age and were more likely to report problems with opiates or cocaine (fewer problems with alcohol or marijuana), be self-referred, be unemployed at admission, and more likely to be separated, divorced or widowed (DASIS Report, May 20, 2005).

Assessment and Treatment Process

The multiplicity of problems that characterize the lives of addicted women require a redesign of traditional evaluation and treatment processes. Assessment instruments and processes for addicted women need to be global as opposed to categorical and continuing rather than an intake activity (Wechsberg, 1995). The treatment itself needs to focus on the whole spectrum of problems presented by the addicted woman rather than focusing narrowly on the problem of addiction (Brown, Huba, and Melchior, 1995; Wechsberg, 1995). The nature and number of these problems may dictate a longer period of indicated treatment for women. For example, time and physical healing may be required for alcoholic women to recover from alcohol-induced neuropsychological deficits before intensive psychotherapies can be used effectively (Hill, in Wilsnack, 1984).

Traditional confrontational approaches in addiction treatment may be highly inappropriate and even injurious for many addicted women (Murray, 1989; Nelson-Zlupco, 1995; Zweben, 1996). Such traditional approaches require substantial modification for clinical appropriateness and effectiveness (Brown, et al., 1996). Motivational enhancement strategies offer a tested alternative to such clinical tactics (Miller and Rollnick, 1991).

In 1986, a sweeping review of the addiction treatment research concluded that there was little research evidence to support the efficacy of any particular treatment approaches for addicted women (Vannicelli, 1986). Since then, there has been an accumulation of research that is defining the major elements of an evidence-based, gender-specific and family focused model of addiction treatment. Women-specific addiction treatment programs differ significantly in the variety, comprehensiveness, design, duration and cost of services (Grella, et al., 1999). More specifically, they:

- provide outreach services (Reed, 1987)
- focus on addiction as one of multiple problems that require service attention (Nichols, 1985; Wallen, 1992; Zweben, 1996)
- collaborate with multiple helping agencies during the treatment process (Reed, 1987)
- concentrate services in a single, non-stigmatizing service environment (Kaplan-Sanoff and Leib, 1995; Finkelstein, 1993)
- focuses on the needs of the woman and her children
- treat gynecological and medical problems (Burman, 1992)
- provide child care, transportation and housing services (Beckman and Amaro, 1986)
- link clients to domestic violence services
• provide strong female recovery role models (DiMatteo and Cesarini, 1986; Reed, 1987),
• provide all-female groups and female therapists, outreach workers and case managers (Ruggels, et al., 1977; (Woodhouse, 1990)
• place emphasis on client empowerment via the goals of personal and economic self-sufficiency and an emphasis on choices throughout the treatment process (LaFave and Echols, 1998)
• provide women-only, peer support groups within the treatment milieu encouraging sexual autonomy related to desires, preferences, and limits (Nelson-Zlupko, 1995),
• provide case management services to address personal and environmental obstacles to recovery
• provide a longer duration of treatment involvement with a structured program of family-focused aftercare, and
• provide pregnancy-related services

Treatment Outcomes

Addiction treatment outcomes for women are influenced by both client characteristics and program characteristics (Morrissey, Ellis, Gatz, et al, 2005).

Women who complete treatment have nine times the abstinence rates as follow-up as women who did not complete treatment, whereas the abstinence rates of men completing treatment is only three times greater than men who do not complete treatment (Green, 2006).

In spite of the popular conceptions (myths) that women are hard to treat and have poor treatment outcomes, early research suggested that women do as well as men in addiction treatment (Vannicelli, 1984; Annis & Liban, 1980; Toneatto et al, 1992). More recent studies have concluded that women have better post-treatment recovery outcomes than men (Walitzer & Dearing, 2000; McCance-Katz, Carroll & Rounsaville, 1999; Hser, Evans & Huang, 2005; Green, 2006). The latter findings included treatment outcome studies for cocaine and methamphetamine dependence.

Studies of women-only versus gender-mixed treatment programs have produced conflicting results, with some gender-specific programs showing enhanced outcomes (Dahlgren and Willander, 1989), while others revealed no difference in outcome (Copeland et al., 1993).

There is evidence that women-only treatment programs are able to reach those women that otherwise would not seek or complete addiction treatment (Reed and Leibson, 1981). What is most clear from treatment outcomes studies of women is that women have higher retention rates and better post-treatment outcomes in programs in which great numbers of women are treated and which provide a more comprehensive range of gender-specific services (Grella & Greenwell, 2004).

Poorer treatment outcomes for women have been associated with: 1) presence of a disturbed or violent parent during childhood, 2) depressive symptoms, 3) alcohol abuse and violence in partner at time of follow-up, 4) removal of children from home by authorities during follow-up period, and 5) problems handling aggressive impulses (Hover, 1986; Hover, 1987; Bergman, 1985; Walitzer & Dearing, 2000). Involvement with an addicted partner is a major etiological factor in the onset of excessive alcohol and drug
use for women and a major barrier preventing the addicted woman from entering treatment or sabotaging her on-going recovery efforts (Lex, 1994). It should not be surprising, then that unmarried women have better post-treatment recovery rates than those who are married (McCraday and Raytek, 1993). Involvement in methadone treatment has been shown to provide structure and stability in the life of opiate-addicted women, but that many women of these women express concerns about the stigma related to their continued use of methadone (Rosenbaum and Murphy, 1990).

Two just-completed reviews of addiction treatment outcome studies on women (Sun, 2006; Greenfield, Brooks, Gordon, et al, 2006) draw the following conclusions:

- Women with AOD problems are less likely to enter treatment than men with such problems.
- Treatment retention and completion rates are similar for women and men.
- Women as a group do better in residential modalities than modalities of lower intensity.
- Women do better in treatment programs that offer regular individual counseling in addition to non-confrontational group counseling.
- Retention and longer length of treatment is associated with better treatment outcomes for both men and women.
- Provision of child care services increases retention and the positive effects of treatment.
- Provision of case management services improves retention and outcomes.
- Women have better long-term outcomes following treatment than do men.
- Gender-specific treatment is effective but study findings vary on the question of whether gender-specific treatment is more effective than mix-sexed treatment.

Processes and Stages of Recovery

Women have shorter alcoholism careers. Fillmore (1987) found that heavy drinking for women peaked in their thirties and then dropped sharply during their forties and beyond, with a substantial number of women ceasing alcohol consumption after age 60. Fillmore concluded that, in comparison to men, remission of heavy drinking is more likely and more likely to occur earlier. There is further evidence that women have greater prospects for long-term recovery than do men. Humphreys and his colleagues found in a follow-up study of clients eight years post-discharge that women were 1.63 times more likely to be in stable recovery (Humphreys et al., 1997). Mohr, et al., (2001) attributes these enhanced outcomes to the fact that alcoholic women entering treatment have more non-drinking friends who are supportive of their recovery process than do alcoholic men. Recovery friendships and supportive social support networks are a significant motivator toward self-directed recovery for many women. The greater prospects of recovery may also extend to women addicted to drugs other than alcohol. Snow (1973) reported that women addicted to opiates had better long-term recovery rates than men with similar addiction patterns.
Recovery without Treatment/Moderated Recovery

Many young women aged 21-34, who as a group report the highest incidence of alcohol-related problems, will resolve these problems without treatment (Wilsnack, 1989). Such “natural recovery” (the achievement of recovery from addiction without the aid of professionally-directed treatment or sustained involvement in mutual aid groups) is more common in women than in men. In a recent study of natural recovery in women, Copeland (1998) found three themes in the resolution for change decisions: 1) concern for current and future health, 2) a lost sense of self, and 3) concern over the welfare of their children. Strategies that women use to self-manage their own recovery process include management of withdrawal, short-term drug substitution, severing drug-dominated intimate and social relationships, developing new social activities and relationships, and the cultivation of new health-promoting behaviors, e.g., nutrition, fitness, alternative medicine (Copeland, 1998). Those women who cannot achieve natural recovery when compared to those who do are found to have greater problem severity, greater psychiatric co-morbidity, and fewer family and social supports.

Gender differences are also noted in the literature about persons with alcohol problems who resolve such problems through moderating their use rather than by complete abstinence. Sanchez-Craig and her colleagues (1984, 1991) and others (Miller and Joyce, 1979; Elal-Lawrence, et al., 1986; Helzer, et al., 1985) have noted that women more likely than men to achieve successful moderation outcomes. Again, this may be related to the Mohr study (2001) findings that women had richer non-drinking social relationships than men and that such relationships enhanced not only successful abstinence but also served to lower the number of drinks per drinking day among those who did drink. Successful moderation is linked to lower personal vulnerability (e.g., absence of family history, later onset of alcohol/drug use), absence of co-occurring medical/psychiatric illness and significant family and social support (White & Kurtz, in press).

Developmental Stages of Recovery

Recovery for most addicted women is a time-involved, developmental process. Confirming these observations was a recent study (Brown, et al., 2000) concluding that women may be at different stages of change for different problems, e.g., substance use, high risk sexual behaviors, violent relationships, child neglect, and that such change processes must be simultaneously managed. Relapse is often part of the early recovery process for many women. Such relapses can involve the primary drug to which the women was addicted or the use of secondary drugs. Willie (1978) reported that recovered heroin addicts used drugs such as alcohol and cannabis in the first year to cope with the challenges of early recovery. Willie framed such use not as substitute addiction but as an “intermediary stage” of recovery. Similar findings occurred in Copeland’s (1998) study of natural recovery in women. All of the women noted to have developed an initial problem with a substituted drug later resolved this problem. While there is a very real danger of transferring dependencies e.g., from heroin to cocaine or alcohol, episodes of drug substitution are best seen as part of the early recovery process requiring active management than an indicator of either the untreatability of the client or the failure of a particular treatment method.
Recovery Support Structures

Women and cultural minorities affiliate with AA/NA at the same rates as White men (Humphreys, et al., 1994) and at least one report suggests that women may have an easier time affiliating with 12-step groups than do men (Denzin, 1987). This may be related to the fact that alcoholic women are more socially isolated (tell fewer individuals about their drug-related problems) and have less support from their partners for recovery (Bischof, et al., 2000). The percentage of women among AA members has increased from 15 percent in 1955 to 33 percent in 1996 (White, 1998). Special women’s groups within AA grew during these same years. There are feminist-based alternatives to AA (Kirkpatrick, 1976), and AA’s steps have been refined for greater applicability for women (Kasl, 1992; Lerner, 1990). There is also evidence that women, particularly African-American women, may use the church as a sobriety-based support structure (White, Woll & Webber, 2003).

Substance Use and Partner Violence

Alcoholic women tend to select mates who come from family backgrounds similar to their own (Rimmer & Winokur, 1972). This process is referred to as “assortative mating” (Lex, 1991) and has been linked to the victimization histories of addicted women. The research literature on addicted women portrays a picture of unstable marital/intimate relationships characterized by low levels of emotional satisfaction and increased levels of marital conflict that can escalate into the emotional/physical abuse of the alcoholic woman. This picture must be viewed in the context of the high rate of victimization of these clients. Research has confirmed the propensity of traumatized women to “repeat and re-enact subordination and victimization in their interpersonal attachments” (Bollerud, 1990). Breaking these cycles of victimization requires specialized treatment approaches (Herman and Schatzow, 1984).

Sentencing Issues

Few studies have distinguished the effectiveness of particular DUI sanctions by gender. One notable exception to this rule was a study of the effects of victim impacts panels on DUI recidivism. That study found that female repeat offenders who were referred to victim impact panels were twice as likely to recidivate as female repeat offenders not referred to a panel (C’ De Baca, Lapham, Liang & Skipper, 2001). The authors suggested the possibility that victim impact panel could actually have a negative effect on the female repeat offender. The potential effectiveness or ineffectiveness of remedial education for the female DUI offender may well be an issue of timing. We suspect that early exposure to an impact panel may elicit too much sympathy for women already steeped in self blame and may increase her risk of drinking due to shame and guilt, while introducing it later might prove beneficial.
Tips for Enhancing Recovery among Women

Police officers, evaluators, treatment specialists, prosecutors, judges, probation officers and Secretary of State Hearing Officers all have opportunities to interact with women who have driven under the influence of alcohol and who have significant alcohol and other drug related problems. These interactions offer tremendous opportunity to influence movement toward sustained recovery. In this section, we offer a few simple tips to reduce your stress, enhance your effectiveness, increase her accountability, and improve outcomes for addicted women.

Establish Rapport and Safety. A helping alliance includes respect, rapport and safety. With histories of physical and or sexual abuse that spanned early developmental years through their adult lives, addicted women carry deeply embedded messages that the world is not a safe place, and that people, especially authority are cruel. Women in recovery talk about kindness from authority as if it were a rare and precious commodity. With harshness her anxiety level soars, she closes up and loses the capacity to hear you--she’s frantically trying to defend herself. In an environment of safety and kindness she opens up and wants to comply with your expectations. Your stress level and hers will go down, and outcomes will improve.

Set Clear Expectations and Monitor Performance. Communicate in behavioral and measurable terms what is expected, acknowledge positive recovery-related activities and continue to monitor her compliance with positive feedback and support.

Convey Hope and Praise. Hope and affirmation are the lifeblood of recovery for women. Most addicted women have been socially stigmatized, victimized and blamed by systems they’ve reached out to. Hungry for approval from authority, acknowledging her positive efforts will motivate her and other women witnessing such praise. Recognizing and complimenting does not take a degree in counseling, but the payoff is tremendous.

Educate Yourself about the Stages of Recovery. We recommend several resources to enhance your education on the recovery process. The first is the book Changing for Good by John Prochaska, John Norcross and Carlo DiClemente, which demonstrates that timing in partnership with the appropriate intervention can interrupt addictive patterns. The second is an essay entitled The Varieties of Recovery Experience by William White and Ernest Kurtz that is included in a monograph entitled Recovery Management that is distributed by the Great Lakes Addiction Technology Transfer Center. A third resource is an essay on the developmental stages of recovery for addicted women that summarizes a study of recovering women in Illinois’ Project SAFE sites—an award winning program that treated women with histories of addiction-related abuse or neglect of their children. This essay is included as an appendix to this monograph.

Discover and Ignite Her Motivators. Every woman will easily reveal what motivates her, when we set aside our own biases, values and beliefs. If you don’t believe us, try this, for the next week, ask every woman you meet the same question, nothing deep or personal, but something as simple as
• Best birthday you ever had
• Something you enjoy

As she answers, she will reveal her values, beliefs, and motivators. Just as each woman has a unique face and personality, each possesses a unique set of values, beliefs, strengths, weaknesses and interests. By listening carefully you will discover her unique motivators and how to ignite those. She will easily share those **when she feels safe, and when she feels heard.**

**Help Each Client Increase Her Recovery Capital.** Recovery capital is the internal and external resources that can be mobilized to initiate and sustain recovery. Here are examples of four categories of recovery capital:

- **Social Capital** – Social relationships that encourage and support recovery.
- **Physical Capital** – Financial such as income, savings, a home, investments.
- **Human Capital** – Knowledge, skills, health, problem solving abilities.
- **Cultural Capital** – Beliefs, behavioral patterns, qualities that emanate from membership in a particular culture that encourage recovery.

We can help woman expand their recovery support resources by recognizing and enhancing their recovery capital, and suggesting simple assignments linked to her motivators. Here’s an example of an assignment for a woman who wanted to get her GED but suffered from testing anxiety.

- **Go to the library and request information on getting a GED. Don’t sign up yet if you feel overwhelmed, just get the information.**
- **Ask women in AA who got their GED’s in recovery to share when, where, how and any obstacles they overcame to get their GED.**

This assignment helps her understand the GED process and allows choices about when to begin. Studying for the GED builds confidence, enhances motivation and instills hope that she can learn, grow and change. Talking to other women helps build a recovery support network. These are examples of building recovery capital.

**Where Possible, Shift Your Paradigm to “No Failure. Just Feedback”** A key to ongoing recovery is the ability to explore what doesn’t work and try new strategies. Relapses & acts of non-compliance can be important sources of feedback. Women in early recovery are suffering from the combined effects trauma, withdrawal and cognitive impairment of early recovery. Lake County and Cook County in Illinois both committed resources to establish specialized services for DUI Women and secured specialized training on gender specific models for their staff. Rather than attributing deviant behavior as a product of personal failure, well trained staff will further assess and adapt approaches before imposing sanctions.
Visit Local Treatment Programs for Women. Visiting local treatment programs that have gender competent services for women will breathe life into the knowledge you’ve acquired about women and addictions. Collaboration improves treatment outcomes, eases the referral process for you, and will help you align your goals and her goals in treatment. Considering that women who complete treatment have nine times the abstinence rates as women who didn’t complete treatment, it’s well worth it to have a good working relationship with treatment programs.

Visit Open Recovery Support Meetings. We recommend acclimating yourself to local recovery support groups by reviewing literature and web sites of such groups (see www.facesandvoicesofrecovery.org, click mutual aid resources) and attending open meetings. You can contact AA (and often NA) through the Yellow Pages of the phone book. Your work will be enriched by hearing the powerful stories of women in long-term recovery whose lives, now meaningful and productive, were once as chaotic and problem-ridden as those of the women clients you now serve. Your ability to understand the core ideas, language and rituals of recovery groups will dramatically enhance your ability to link women to these groups and monitor their participation. You’ll meet women today who are honest, hard working, reliable, a mother, wife, and friend, because someone just like you saw beyond their problems, held them accountable and encouraged them to hang in there for the miracle of recovery.

Attend Meetings And Hear Her Story Encourage current and former clients to invite you when they share their story at an open meeting. Most women will appreciate your interest and be proud to have you there. You will be surprised to learn new things about her as she pours out her truth the AA way. What you learn from her is sure to improve your interactions with other women on your case load.

Start a Women’s Self Help Group In communities that do not have women’s meetings of AA, NA, etc., you may want to help develop such a meeting by inviting AA / NA volunteers to start up meetings and conduct them. Developing such resources can be aided by working with current Hospital and Institution Committees within AA or NA or by setting up an AA/NA advisory group.

Explore Group Supervision Lake County, Illinois and Cook County, Illinois train their staff on conducting group supervision. Groups range from women’s groups, co-ed groups and groups organized by severity/risk, groups for women who have reached abstinence, and those still struggling. Because women are very relationship oriented, they do very well in groups. But, because relapse is common in early recovery, groups for women who are still using get the best outcomes when staff is trained in women’s issues, addiction interruption techniques, and running effective groups. Once mastered, these skills can be important recovery support resources, particularly in communities lacking women’s groups in AA and NA.
Future Directions

Having reviewed the available research literature on women DUI offenders and the broader literature on the treatment of women and having interviewed women DUI offenders and those providing services to these women, we would offer the following ten recommendations related to enhancing the quality of evaluation, education, treatment and supervision of female DUI offenders in the State of Illinois.

1. **Evaluation Instruments**: Develop gender norms for existing evaluation instruments and/or develop an instrument or subscales based specifically on research with, at best, female DUI offenders, and at least, community and clinical samples of women.

2. **Gender Competent Evaluators**: Require all DUI evaluators to complete gender-specific training and hold IAODAPCA’s forthcoming certificate for gender competence.

3. **Recidivist Risk Profile**: Develop a DUI recidivist risk profile that is based exclusively on research with women DUI offenders.

4. **Gender-specific Risk Education**: Audit and revise existing remedial education programs to assure gender competence. Segregate women into specialty groups when there are enough women.

5. **Gender-specific DUI Treatment Models**: Develop models for treating female DUI offenders that incorporate current research findings.

6. **Gender-specific Treatment Specialty**: Encourage the development of gender-specific DUI treatment services to assure enough referrals to organize women’s groups.

7. **Women’s Recovery Support Groups**: Develop a directory of women’s recovery support groups in Illinois and that are available Online. Establish guidelines for establishing local liaison committees between the courts, treatment agencies and recovery mutual aid groups. Develop women’s recovery support groups in communities where they do not exist. Recruit AA/NA volunteers to orient new judges, probation officers and other service roles to local recovery support groups.

8. **Alumni Volunteers**: Recruit, train and supervise a cadre of women in recovery who came through the DUI system who can serve as volunteer recovery coaches to women currently entering the system.

9. **Consumer Feedback on Services**: Conduct a survey of female DUI offenders to solicit feedback related to evaluation, treatment and probation services they have received.

10. **Gender-research**: Encourage all studies done on DUI in Illinois to analyze data for gender differences.

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**About the Authors**: William White (bwhite@chestnut.org), a Senior Research Consultant at Chestnut Health Systems, has worked in the addictions field for more than
35 years. He has served as the evaluator of gender-specific treatment programs and has written extensively about the history of addiction and recovery among American women. Maya D. Hennessey BA, CRADC, MISA II (www.mayahennessey.com) has worked in the addictions field for 30 years as a national consultant, trainer, author specializing in women, addictions and interagency collaboration. She also teaches at Governors State University.

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