

# Women and Addiction: A Trauma-Informed Approach

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**Abstract**—Historically, substance abuse treatment has developed as a single-focused intervention based on the needs of addicted men. Counselors focused only on the addiction and assumed that other issues would either resolve themselves through recovery or would be dealt with by another helping professional at a later time. However, treatment for women's addictions is apt to be ineffective unless it acknowledges the realities of women's lives, which include the high prevalence of violence and other types of abuse. A history of being abused increases the likelihood that a woman will abuse alcohol and other drugs. This article presents the definition of and principles for gender-responsive services and the Women's Integrated Treatment (WIT) model. This model is based on three foundational theories: relational-cultural theory, addiction theory, and trauma theory. It also recommends gender-responsive, trauma-informed curricula to use for women's and girls' treatment services.

**Keywords**—addiction treatment, gender-responsive, service integration, trauma, trauma-informed, women's services

Over the past thirty years, our knowledge of women's lives has increased dramatically, and we have added significantly to our understanding of the treatment needs of women who are addicted to alcohol and other drugs.

In the past, substance abuse treatment was developed as a single-focused intervention. Counselors focused only on the addiction and assumed that other issues would either resolve themselves through recovery or would be dealt with by another helping professional at a later time. However, research shows that a vast majority of addicted women have suffered violence and other forms of abuse. Furthermore, a history of being abused drastically increases the likelihood that a woman will abuse alcohol and other drugs. One of the most important developments in health care over the past several decades is the recognition that a history of serious traumatic experiences plays an often-unrecognized role in a woman's physical and mental health problems (Messina & Grella 2006; Fellitti et al. 1998).

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In one of the first studies on addicted women and trauma, 74% of the addicted women reported sexual abuse, 52% reported physical abuse, and 72% reported emotional abuse. "Moreover, the addicted women were found to have been abused sexually, physically, and emotionally by more perpetrators, more frequently, and for longer periods of time than their non-addicted counterparts. The addicted women also reported more incidents of incest and rape" (Covington & Kohen 1984: 42). More recent studies confirm that the majority of substance-abusing women have experienced sexual and/or physical abuse (Quimette et al. 2000).

## GENDER-RESPONSIVE SERVICES

The research also demonstrates that addiction treatment services for women (and girls) need to be based on a holistic and woman-centered approach that acknowledges their psychosocial needs (Orwin, Francisco & Bernichon 2001; Grella, Joshi & Hser 2000; Grella 1999). This author defines gender-responsive/woman-centered services as the creation of an environment—through site selection, staff selection, program development, and program content and materials—that reflects an understanding of the realities of

women's and girls' lives and that addresses and responds to their challenges and strengths.

### The Issue of Gender

The keys to developing effective services for women are acknowledging and understanding their life experiences and the impact of living as a female in a male-based society. In other words, gender awareness must be part of the clinical perspective.

Gender shapes the contexts in which women live and, therefore, their lives. Research suggests that social and environmental factors (including gender socialization, gender roles, and gender inequality) account for many of the behavioral differences between women and men. Gender differences are neither innate nor unchangeable; they are ascribed by society and relate to expected social roles, so it is important to acknowledge some of the dynamics in a gendered society. In most of the world today, the male gender is dominant, and its influence is so pervasive that it often is unseen. One result is that programs and policies called "gender neutral" are actually male based. For example, program administrators may take a traditional program designed for men, change the word "he" to "she," and call the result a "program for women."

Differences also exist between women, based on a number of factors (such as race and socioeconomic status), and these can influence a helping professional's views of gender-appropriate roles and behaviors. Regardless of their differences, all women are expected to incorporate the gender-based norms, values, and behaviors of the dominant culture into their lives. As Kaschak (1992: 5) states:

The most centrally meaningful principle on our culture's maturing map is gender, which intersects with other culturally and personally meaningful categories such as race, class, ethnicity, and sexual orientation. Within all of these categories, people attribute different meanings to femaleness and maleness.

### Gender Responsive Principles

In a research-based report for the National Institute of Corrections, which states the guiding principles for working with women, gender is the first principle. A multidisciplinary review of the literature and research on women's lives in the areas of substance abuse, trauma, health, education and training, mental health, and employment was conducted as part of this project. The following principles are applicable to any setting that serves women (Bloom, Owen & Covington 2003):

- *Gender*: Acknowledge that gender makes a difference.
- *Environment*: Create an environment based on safety, respect, and dignity.
- *Relationships*: Develop policies, practices, and programs that are relational and promote healthy connections to children, family, significant others, and the community.

- *Services*: Address substance abuse, trauma, and mental health issues through comprehensive, integrated, and culturally relevant services.
- *Socioeconomic status*: Provide women with opportunities to improve their socioeconomic conditions.
- *Community*: Establish a system of comprehensive and collaborative community services.

### Common Themes in the Lives of Addicted Women

Several years ago the United Nations developed a monograph on the treatment of drug-addicted women around the world. At a meeting of experts held in Vienna, it became clear that many of the issues that addicted women struggle with are universal:

- Shame and stigma
- Physical and sexual abuse
- Relationship issues:
  - fear of losing children
  - fear of losing a partner
  - needing a partner's permission to obtain treatment
- Treatment issues:
  - lack of services for women
  - not understanding women's treatment
  - long waiting lists
  - lack of childcare services
- Systemic issues:
  - lack of financial resources
  - lack of clean/sober housing
  - poorly coordinated services

It is important to note that helping professionals around the world report an association between addiction and all forms of interpersonal violence (physical, sexual and emotional) in women's lives (UNODC 2004).

### WOMEN'S INTEGRATED TREATMENT (WIT)

The recurring theme of the interrelationship between substance abuse and trauma in women's lives indicates the need for a multifocused approach to services. One treatment model, developed by the author, is called Women's Integrated Treatment (WIT). The WIT model is based on: (1) the definition of and principles for gender-responsive services (previously discussed), (2) a theoretical foundation (discussed below), and (3) multidimensional therapeutic interventions. One completed study (SANDAG 2007) and preliminary data from two ongoing experimental randomized control-group studies (Messina & Grella 2008; Bond & Messina 2007) show positive results for the WIT model (see further discussion in the Research Findings section below).

### Theoretical Foundation

In order to develop gender-responsive services and treatment for women, it is essential to begin with a

theoretical framework. This is the knowledge base on which programs are developed. The three fundamental theories underlying the WIT model are: relational-cultural theory, addiction theory, and trauma theory.

**Relational-cultural theory.** A link between understanding women's addiction and creating effective treatment programs for women is understanding the unique characteristics of women's psychological development and needs. Theories that focus on female development, such as relational-cultural theory (Jordan 1991), posit that the primary motivation for women throughout life is the establishment of a strong sense of connection with others. Relational-cultural theory (RCT) developed from an increased understanding of gender differences and, specifically, the different ways in which women and men develop psychologically. According to this theory, females develop a sense of self and self-worth when their actions arise out of, and lead back into, connections with others. Connection, not separation, is the guiding principle of growth for women and girls. RCT describes the outcomes of growth-fostering relationships, as well as the impact of disconnections. Disconnections happen at the sociocultural level, as well as the personal level, through racism, sexism, heterosexism, and classism. The issues of dominance and privilege are two aspects of relational-cultural theory (Jordan & Hartling 2002).

**Addiction theory.** In recent years, health professionals in many disciplines have revised their concepts of all diseases and have created a holistic view of health that acknowledges the physical, emotional, psychological, and spiritual aspects of disease. In a truly holistic model, the environmental and sociopolitical aspects of disease are also included. The WIT model uses a holistic model of addiction (which is essentially a systems perspective) to understand every aspect—physical, emotional, and spiritual—of the woman's self as well as the environmental and sociopolitical aspects of her life, in order to understand her addiction. An addicted woman typically is not using alcohol or other drugs in isolation, so her relationships with her family members and other loved ones, her local community, and society are taken into account. For example, even though a woman may have a strong genetic predisposition to addiction, it is important to understand that she may have grown up in an environment in which addiction and drug dealing are commonplace (Covington 2007).

Although the addiction treatment field considers addiction a "chronic, progressive disease," its treatment methods are more closely aligned to those of the acute care medical model than the chronic-disease model of care (White, Boyle & Loveland 2002). An alternative to the acute-intervention model for treating disease is "behavioral health recovery management" (BHRM). This concept grew out of and shares much in common with disease management approaches to other chronic health problems; it focuses on quality-of-life outcomes as defined by the individual and family. It also

offers a broader range of services earlier and extends treatment well beyond traditional (medical) services. The BHRM model extends the current continuum of care for addiction by including: (1) pretreatment (recovery-priming) services, (2) recovery mentoring through primary treatment, and (3) sustained, post-treatment, recovery-support services (Boyle et al. 2005). BHRM is strongly aligned with the concepts of holistic health care.

An integration of BHRM and the holistic health model of addiction is the most effective theoretical framework for developing treatment services for women because it is based on a multidimensional framework. It allows clinicians to treat addiction as the primary problem while also addressing the complexity of issues that women bring to treatment: genetic predispositions, health consequences, shame, isolation, histories of abuse, or a combination of these. When addiction has been a core part of the multiple aspects of a woman's life, the treatment process requires a holistic, multidimensional approach.

**Trauma theory.** The third theory integrated into the WIT model is based on the principles of trauma-informed services (Harris & Fallot 2001) and the three-stage model of trauma recovery developed by Dr. Judith Herman (1997, 1992).

### Understanding Trauma

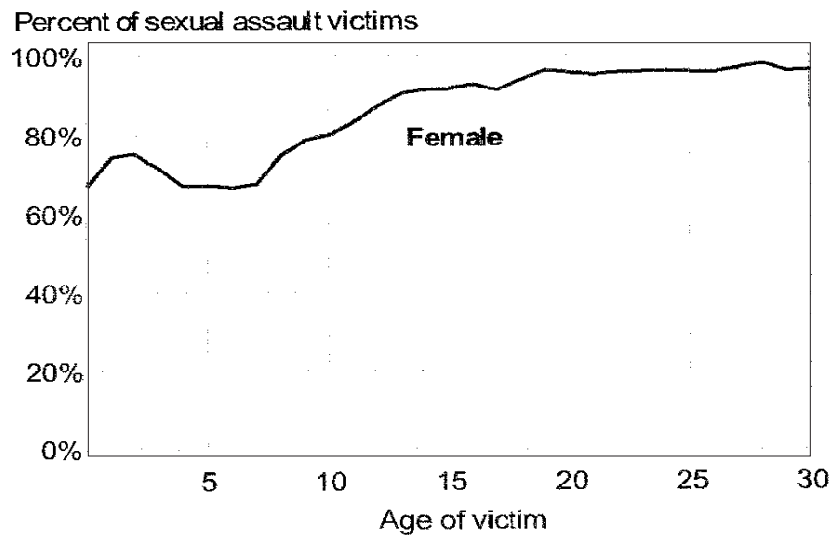
Trauma is not limited to suffering violence; it includes witnessing violence as well as stigmatization because of gender, race, poverty, incarceration, or sexual orientation. The terms violence, trauma, abuse, and posttraumatic stress disorder (PTSD) often are used interchangeably. One way to clarify these terms is to think of trauma as a response to violence or some other overwhelmingly negative experience (e.g., abuse). Trauma is both an event and a particular response to an event. The response is one of overwhelming fear, helplessness, or horror. PTSD is one type of disorder that results from trauma.

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV TR) lists the following symptoms of PTSD (APA 2000: 427-429):

- Re-experiencing the event through nightmares and flashbacks
- Avoidance of stimuli associated with the event (for example, if a woman was assaulted by a blonde man, she may fear and want to avoid men with blonde hair)
- Estrangement (the inability to be emotionally close to anyone)
- Numbing of general responsiveness (feeling nothing most of the time)
- Hypervigilance (constantly scanning one's environment for danger, whether physical or emotional)
- Exaggerated startle response (a tendency to jump at loud noises or unexpected touch)

There are two types of PTSD: simple and complex. Complex PTSD usually results from multiple incidents of

**FIGURE 1**  
**Female Proportion of All Sexual Assault Victims**



Source: Bureau of Justice Statistics 2000

abuse and violence (such as childhood sexual abuse and domestic violence). A single traumatic incident in adulthood (such as a flood or accident) may result in simple PTSD.

A review of studies that examined the combined effects of posttraumatic stress disorder and substance abuse found more comorbid mental disorders, medical problems, psychological symptoms, inpatient admissions, interpersonal problems, lower levels of functioning, poor compliance with aftercare and motivation for treatment, and other significant life problems (such as homelessness, HIV, domestic violence, and loss of custody of children) in women with both disorders than in women with PTSD or substance abuse alone (Najavits, Weiss & Shaw 1997).

### Gender Differences

There is a difference between women and men in terms of their risk for physical and sexual abuse. Both female and male children are at relatively equal risk from family members and people known to them. However, as males age, they are more likely to be harmed by enemies or strangers, whereas women are more likely to be harmed by their lovers or partners (Kendall-Tackett 2005; Covington 2003, 1999).

In adolescence, boys are at risk if they are gay, young men of color, or gang members. Their risk is from people who dislike or hate them. For a young woman, the risk is in her relationships, from the person(s) to whom she is saying, "I love you." For an adult man, the risk for abuse comes from being in combat or being a victim of crime. His risk is from "the enemy" or from a stranger. For an adult woman, the primary risk is again in her relationship with

the person to whom she says, "I love you." Clinically, it is very possible that this may account for the increase in mental health problems for women. In short, it is more confusing and distressing to have the person who is supposed to love and care for you do harm to you than it is to be harmed by someone who dislikes you or is a stranger.

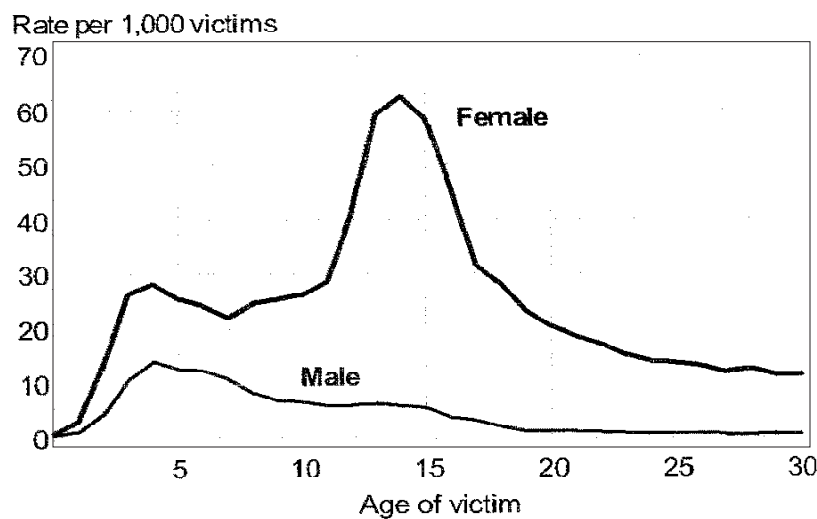
Two graphs from the Bureau of Justice Statistics (2000) indicate some of these gender differences. Figure 1 shows that a significant number of males are sexually abused as children. From ages 1 to 10, approximately 35% to 20% are male and 65% to 80% are female. However, in adult life, victims of sexual abuse are almost 100% female. Figure 2 indicates that the age of greatest risk for sexual assault for males is age five; for females it is age fourteen.

Of course, different women have different responses to violence and abuse. Some may respond without trauma because they have coping skills that are effective for a specific event. Sometimes trauma occurs but is not recognized immediately, because the violent event is perceived as normal. Many women who used to be considered treatment failures because they relapsed are now recognized as trauma survivors who returned to alcohol or other drugs in order to medicate the pain of trauma. Integrating trauma services with addiction treatment reduces the risk of trauma-based relapse.

### BECOMING TRAUMA-INFORMED

As the understanding of traumatic experiences increases among clinicians, mental health theories and practices are

**FIGURE 2**  
**Age Distribution of Sexual Assault Victims by Gender**



Source: Bureau of Justice Statistics 2000

changing. It is important for service providers to understand trauma theory as a conceptual framework for clinical practice and to provide trauma-informed services for their clients. According to Harris & Fallot (2001), trauma-informed services do the following:

- Take the trauma into account
- Avoid triggering trauma reactions or retraumatizing the woman
- Adjust the behavior of counselors and staff members to support the woman's coping capacity
- Allow survivors to manage their trauma symptoms successfully so that they are able to access, retain, and benefit from the services

For treatment providers who want to include or expand trauma services, the following model provides a description of how to integrate trauma-informed services and trauma treatment into addiction treatment programs.

### A Three-Stage Model for Trauma Recovery

In *Trauma and Recovery*, psychiatrist Judith Herman (1997) defines trauma as a disease of disconnection. She presents a three-stage model for trauma recovery: (1) safety, (2) remembrance and mourning, and (3) reconnection. It is important to note that these three stages are interdependent and usually do not occur in a linear fashion.

**Stage 1: Safety.** The first stage focuses on caring for oneself in the present. On entering addiction treatment, a woman typically is in Stage 1 and her primary need is safety. "Survivors feel unsafe in their bodies. Their emotions and

their thinking feel out of control. Often, they also feel unsafe in relation to other people" (Herman 1997: 160).

To assist women in changing their lives, a safe environment in which the healing process can begin to take place must be created. Counselors can help women to feel safe by ensuring as much as possible that there are appropriate boundaries between the clients and all the helping professionals (that is, the environment is free of physical, emotional, and sexual harassment and abuse). Although it may be possible for a clinician to guarantee absolute safety only in a private practice setting, participants in treatment programs need to know that this environment is likely to be safe for them. Counselors also should assess each woman's risk of domestic violence and, if needed, provide resources to a woman so that she can get help. These resources include telephone numbers for the local domestic violence hotline and the local women's shelter.

Many chemically-dependent trauma survivors use drugs to medicate their anxiety or depression because they know no better ways to comfort themselves. Counselors can teach women to feel safe internally by teaching them to use self-soothing techniques, rather than drugs, to alleviate anxiety and depression. Self-soothing can include activities such as reading, walking, music, meditation, and bubble baths.

Herman emphasizes that a trauma survivor who is working on safety issues needs to be in a woman-only recovery group (including the facilitator). Until they are in Stage 3 (reconnection), women may not want to talk about sensitive issues in groups that include men. Herman cites Twelve Step



groups as the type appropriate for Stage 1 (safety) recovery because of their focus on present-tense issues of self-care in a supportive, structured environment. This safety stage focuses on issues that are congruent with the issues of beginning recovery.

**Stage 2: Remembrance and mourning.** A woman who is stabilized in her addiction treatment may be ready to begin Stage 2 trauma work. Stage 2, remembrance and mourning, focuses on trauma that occurred in the past. For example, in a survivors' group, participants tell their stories of trauma and mourn their old selves, which the trauma destroyed. During this phase, women often begin to acknowledge the incredible amount of loss in their lives. Although the risk of relapse can be high during this phase of work, the risk can be minimized through anticipation, planning, and the development of self-soothing mechanisms.

**Stage 3: Reconnection.** Stage 3 focuses on developing a new self and creating a new future. Stage 3 groups traditionally are unstructured and heterogeneous. This phase of trauma recovery corresponds to the ongoing recovery phase of addiction treatment. For some women, this work can occur only after several years of recovery.

### The Trauma-informed Environment

In women's treatment programs, sensitivity to trauma-related issues is critical for a healing environment. A calm atmosphere that respects privacy and maximizes the choices a woman can make will promote healing. Staff members should be trained to recognize the effects of trauma, and clients should have a clear understanding of the rules and policies of the program. A trauma-informed environment includes:

- Attention to boundaries—between staff members and participants, among participants, and among participants and visitors. For example, clients should be given permission to say “no” to hugs. Hugging may be an expression of positive emotion for some women, but for those who have been traumatized it could represent an undesired intrusion into their personal spaces.
- Language that communicates the values of empowerment and recovery. Punitive approaches, shaming techniques, and intrusive monitoring are not appropriate.
- Staff members who adopt the “do no harm” credo to avoid damaging interactions. Conflict is dealt with through negotiation.

### Women in the Criminal Justice System

Understanding the impact of trauma is particularly important when working with women in the criminal justice system. Unfortunately, standard management practices—such as searches, seclusion, and restraint—may traumatize or retraumatize many females. Experiences in the criminal justice system can trigger memories of earlier abuse. It can be retraumatizing when a survivor of sexual abuse has a body search or must shower with male correctional officers

nearby. It can be retraumatizing when a battered woman is yelled at or cursed at by a staff person. Incarceration can be traumatizing in itself, and the racism and class discrimination that are characteristic of the criminal justice system can be further traumatizing.

### LINK BETWEEN TRAUMA, SUBSTANCE ABUSE AND OTHER HEALTH ISSUES

Figure 3 helps to outline the process of trauma and its interrelationship with substance abuse and other disorders. Trauma begins with an event or experience that overwhelms a woman's normal coping mechanisms. There are physical and psychological reactions in response to the event: these are normal reactions to an abnormal or extreme situation. This creates a painful emotional state and subsequent behavior. These behaviors can be placed into three categories: retreat, self-destructive action, and destructive action. Women are more likely to retreat or be self-destructive, while men are more likely to engage in destructive behavior (Covington 2003).

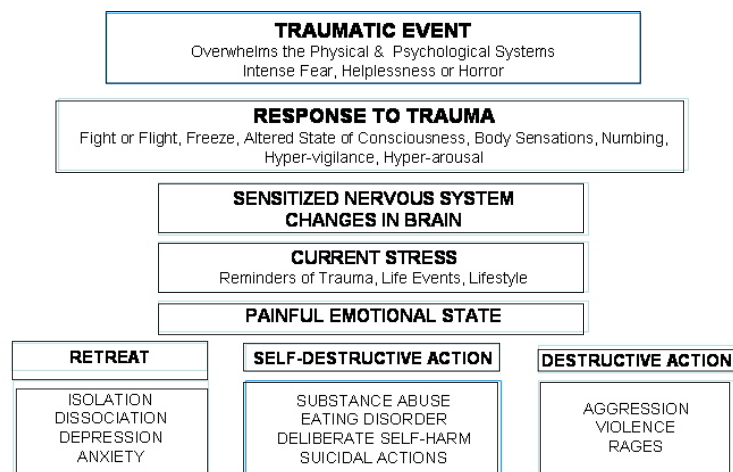
As was noted earlier, one of the most important developments in health care since the 1980s is the recognition that serious traumatic experiences often play an unrecognized role in a woman's physical and mental health problems. For many women, a co-occurring disorder is trauma related. The Adverse Childhood Experiences Study (Felitti et al. 1998) shows a strong link between childhood trauma and adult physical and mental health problems. Eight types of childhood traumatic events were assessed (emotional abuse and neglect, physical neglect, physical abuse, sexual abuse, family violence, parental separation/divorce, incarcerated family member, and out-of-home placement). A score of five or more reflected an increased risk of both mental and physical health problems in adult lives. This study was a model for research done on women in the criminal justice system. For women who scored seven or more, the risk of a mental health problem was increased by 980% (Messina & Grella 2006).

Addicted women are more likely to experience the following co-occurring disorders: depression, dissociation, post-traumatic stress disorder, other anxiety disorders, eating disorders, and personality disorders. Mood disorders and anxiety disorders are the most common. Women are commonly diagnosed as having “borderline personality disorder” (BPD) more often than men. Many of the descriptors of BPD can be viewed differently when one considers a history of childhood and adult abuse. The American Psychiatric Association is considering adding the diagnosis of “complex PTSD” in the next edition of the DSM (Herman 1997).

### CREATING PROGRAMS FOR WOMEN AND GIRLS

In developing gender-responsive services, one important ingredient is the curriculum/material used. The

**FIGURE 3**  
**Process of Trauma**



Source: Covington 2003

following are three manualized curricula that are designed for working with women and girls. They are theoretically based and trauma-informed, each with a facilitator's guide and a participant's workbook. Each of the following curricula uses cognitive-behavioral, relational, and expressive arts techniques.

### **Helping Women Recover: A Program for Treating Addiction**

The three theories of addiction, trauma, and women's psychological development create the foundation of the seventeen-session program. The four modules focus on the issues of self, relationship, sexuality, and spirituality (Covington 2008, 1999). There is also a special edition for women in the criminal justice system.

### **Voices: A Program of Self-Discovery and Empowerment for Girls**

This is the girls' version of *Helping Women Recover* (Covington 1999). There are eighteen sessions with four modules: Self, Connecting with Others, Healthy Living, and The Journey Ahead. The foundation of this program material is based on the three theories mentioned above, with the addition of resiliency theory and attachment theory (Covington 2004).

### **Beyond Trauma: A Healing Journey for Women**

This eleven-session program focuses on three areas: teaching women what trauma and abuse are, helping them to understand typical reactions, and developing coping skills.

The foundation of this material is the work of Judith Herman and several other trauma theorists (Covington 2003). The program materials include three DVDs: two for training staff and one for use with clients. *Beyond Trauma* (BT) can be used alone or following *Helping Women Recover* (HWR) to deepen the trauma work begun in HWR.

### **Research Findings**

One completed study of the Women's Integrated Treatment (WIT) model using *Helping Women Recover* and *Beyond Trauma* with women in a residential program with their children demonstrated a decrease in depression (using Beck's Depression Inventory) and trauma symptoms (using the Trauma Symptom Checklist – 40 scale). The first 45 days in treatment were used as an orientation phase. The decrease in symptomatology from admission to day 45 indicates the importance and potential impact of the treatment environment itself. The women then participated in the 17-session *Helping Women Recover* (HWR) program followed by the *Beyond Trauma* (BT) program. There was a significant decrease in both depression and trauma symptoms at the completion of HWR ( $p \leq .05$ ). There was further improvement ( $p \leq .05$ ) when the women participated in the BT groups that followed HWR. Further details on this research project are discussed in the article entitled "Evaluation of a Trauma-Informed and Gender-Responsive Intervention for Women in Drug Treatment" in this issue.

In addition, empirical validation for HWR and BT is being tested via two experimental studies funded by the

National Institute on Drug Abuse (NIDA). Preliminary evidence from the first NIDA study shows significant improvement during parole among previously incarcerated women who were randomized to a women's integrated prison treatment program using HWR and BT sequentially, as compared to women who were randomized to a standard prison therapeutic community. Women who participated in the WIT program were significantly more likely to be participating in voluntary aftercare treatment services (25% vs. 4%) and significantly less likely to be incarcerated at the time of the six-month follow-up interview (29% vs. 48%) compared to women who participated in the standard treatment (Messina & Grella 2008). Another randomized study among women participating in drug court treatment settings is currently underway and results should be available in 2009 (Bond & Messina 2007).

Focus group results also indicate strong support and high satisfaction for the curricula mentioned above from drug court and prison participants and staff (Messina & Grella 2008; Bond & Messina 2007). While the available empirical evidence for both HWR and BT are in early stages, the findings are promising.

### PROVIDING TREATMENT

Trauma can skew a woman's relational experiences and hinder her psychological development. Because it can affect the way a woman relates to staff members, her peers, and the therapeutic environment, it is helpful to ask, "Is this person's behavior linked to her trauma history?" However, traditional addiction, and/or mental health treatment, often does not deal with trauma issues in early recovery, even though they are primary triggers for relapse among women and may be underlying their mental health disorders. Many treatment providers lack the knowledge and understanding of what is needed in order to do this work.

Here are three important things that can be done in treatment programs:

1. Educate women as to what abuse and trauma are. Women often do not know that they have been abused, nor do they have an understanding of PTSD.
2. Normalize their reactions. It is important that women learn that their responses are normal, given their experiences. The DSM has stated that trauma responses are normal reactions to abnormal situations.
3. Provide coping skills. There are grounding and self-soothing techniques (i.e., breathing exercises) that

women can learn to help themselves cope with their traumatic experiences. (See Covington 2003, *Beyond Trauma: A Healing Journey for Women* for specific techniques to use in individual and group therapy).

### Avoid Revictimization and Retraumatization

A woman who has experienced a traumatic event also experiences increased vulnerability. She may have difficulty tolerating, expressing, and/or modulating her emotions. This results in what is called "emotional dysregulation." An example of this is when she overresponds to neutral cues and underresponds to danger cues. Therefore, traumatized women are at increased risk of similar, repeated revictimization. "Retraumatization" refers to the psychological and/or physiological experience of being "triggered." That is, a single environmental cue related to the trauma—such as the time of year, a smell, or a sound—can trigger a full fight-or-flight response. Often, substance abuse treatment providers hesitate to provide trauma services for women in their programs because of the fear of "retriggering" them. Triggers in the environment cannot be completely eliminated. What is important is to create a safe environment in which women can learn coping skills. This is the reason that the therapeutic environment is so important for women: they must feel safe.

### CONCLUSION

Historically, substance abuse treatment programs were designed for the needs of a predominantly male client population. Over the past three decades, researchers and treatment providers have begun to identify the characteristics and components of successful treatment programs for women. A solid body of knowledge has now been developed that reflects the needs of women in treatment, and there is both a definition of and principles for the development of gender-responsive treatment. Women's exposure to violence has emerged as a critical factor in treatment. Therefore, it is imperative that substance abuse treatment services become integrated, incorporating what we have learned from relational-cultural theory (women's psychosocial development), addiction theory, and trauma theory. Such a gender-responsive and trauma-informed program can provide the safe, nurturing, and empowering environment that women need to recover, heal, and find their inner strengths.

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