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The past 30 years have seen an increase in funding and focus on women's substance abuse treatment. We know that women often face treatment issues that differ from men and require gender-specialized treatment approaches to address these issues. Publicly-funded, as well as private treatment programs have increased their services to women and have developed specialized programs to meet the needs of pregnant and parenting women. Despite the gains of the past three decades, women remain under-represented in the substance abuse treatment field. Over the course of a lifetime, men with substance use disorders are more likely to receive specialized addiction treatment than women. Women are less likely than men to enter any type of treatment. If they do receive treatment, women are less likely than men to be treated in specialized substance abuse programs (Greenfield, et al., 2007).

This continuing gender disparity in substance abuse treatment has worrisome implications for women. Women who abuse drugs and alcohol tend to develop substance-related problems earlier than men, and they tend to report more severe consequences than men (Green, 2006). In addition, women tend to become more impaired by these problems than men. Negative substance-related consequences experienced by women include: physical and emotional health problems; interpersonal disruptions; economic decline; and an overall reduced ability to function independently. Women tend to not only face more barriers than men, but they often deal with a wider variety of barriers. Women are more likely than men to experience barriers related to their personal characteristics, the social and cultural setting, and treatment program limitations. The greater the number of barriers a person faces with regard to addiction treatment, the less likely that person will receive and complete treatment. The considerable gender gap in substance abuse treatment means that women are not receiving the help they need to curb an often rapid and severe decline in functioning.

This article explores some of the reasons for the gender gap in substance abuse treatment. These reasons or "barriers to treatment" limit or obstruct women from getting the professional help they need at a number of critical stages in the treatment process. In addition, this article presents a clinically-oriented review of the literature on barriers to treatment for women. Substance abuse describes the broad category of any substance use disorder from abuse to addiction. Although the literature speaks of "women" in general, there are significant differences among women. The barriers for an alcoholic middle-aged white professional single woman may differ from barriers faced by a cocaine-abusing impoverished pregnant Latina adolescent, or an elderly African-American widow who doesn't know how to stop abusing her pain medications.

Barriers may begin with impediments that prevent the correct identification and diagnosis of substance abuse disorders in women. Women who do realize they need help to overcome their substance use problems often face other barriers

that reduce access to appropriate treatment. Even following admission to treatment, women are confronted with barriers that make it difficult to engage and remain in treatment. Although this article presents the barriers in three categories — internal barriers, social barriers and treatment program barriers — it is important to realize that these categories may synergistically combine to create more difficult obstacles to overcome.

Internal treatment barriers for women

Internal barriers refer to the obstacles to treatment that are based within the psyche or attitudes of the woman, including: low motivation for treatment; denial of problems; misperceptions about substance abuse treatment programs; psychological problems; internalization of negative social attitudes toward female substance abusers; self-definition as a person who does or does not abuse substances; and independent attitudes regarding help seeking and self-reliance.

Low motivation. One of the biggest obstacles to treatment for substance-abusing parents is low motivation. Even the potential loss of children to state custody or the possibility of being reunited with children often is not sufficient to motivate parents to engage in substance abuse treatment (Columbia University, 1999). However, motivation does not exist in a vacuum. Instead, motivation is the barrier that most often is presented to the outside world. Other internal barriers lie underneath and support the apparent low motivation for substance abuse treatment.

Rather than dismiss a woman's lack of interest in substance abuse treatment as "denial" or "obstinacy," it is important for us to help her to uncover these barriers and increase her motivation for treatment.

Denial. Denial is a major internal barrier that lowers motivation for treatment. It occurs when a person lacks awareness that she has a problem with substance use, and may be due to a lack of understanding of what constitutes substance abuse. Women often do not identify their behaviors as substance abuse. They are more likely than men to blame their substance use on stressful situations or to think their substance abuse is due to psychological or physical health conditions (Grant, 1997).

Denial also is related to a misunderstanding about the severity of substance use. People deny they have significant substance abuse problems when they think the problems are relatively mild or short-lasting. For example, a woman may rationalize substance use as a way of coping with a crisis or stress, thinking that her substance use will decrease as her other problems are resolved (Beckman, 1994a). Also, women may not realize that their substance abuse is serious enough to warrant treatment, and may mistakenly believe that their drug or alcohol abuse will decrease without professional help.

Education about the symptoms of substance abuse can increase a woman's ability to recognize the problem and reduce denial.

Beliefs about treatment. Even women who are aware of their substance abuse issues may decide not to seek treatment because of their mistaken perceptions about treatment options. Women are less likely than men to know where to get substance abuse treatment (Grant, 1997).

Like others in our society, women hold stereotypical views of substance abuse programs and clients (Copeland, 1997). They may only be aware of expensive private residential clinics and think that treatment would be too expensive or time-consuming for them. Also, they may be put off by misperception that treatment programs are religiously oriented or have too many rules and regulations. Women also may not see themselves as "substance abuse clients" because they think they are different from the women who use this service. They may not realize that others are addicted to their specific drug of choice or may not want the type of treatment offered to them. This is especially true for opiate-addicted women who do not want the option of medication maintenance with methadone.

These misperceptions create barriers that could be remedied by positive educational messages about the variety of treatment options for women.

Psychological problems. Women who have substance abuse problems are more likely than men to have higher rates of psychological conditions, such as depression and anxiety. These problems often become barriers to treatment (Green, 2006). For example, depressive disorders increase feelings of hopelessness and fatigue and reduce the energy required to go to treatment. Anxiety disorders, such as social anxiety, panic attacks and agoraphobia tend to confine women to their homes and reduce the courage it takes to enter treatment. Substance-abusing women also are more likely to have histories of emotional, physical and sexual abuse trauma than men, and the perpetrators in these situations often were men. These histories of trauma increase apprehension of engaging in the prevalent model of mixed-gender treatment (Greenfield, et al., 2007).

Women who have psychological problems, and are motivated for treatment, tend to access psychiatric care rather than substance abuse treatment. Their psychological conditions may be more apparent and distressing to themselves and others. For instance, a woman who purges after marijuana-induced food binges may be more likely to perceive her problem as bulimia rather than substance abuse. She also may be more likely to seek eating disorder treatment than substance abuse treatment. If the woman is fortunate, her substance abuse will be identified by her mental health care provider. More likely, as we will see later, it will remain undiagnosed and untreated. As we know, untreated substance abuse may decrease the effectiveness of psychiatric treatment and may increase

the likelihood of dropping out of treatment.

We must do more to educate the public and healthcare providers about how substance abuse interacts with psychiatric conditions and how psychiatric symptoms may mask underlying substance use disorders.

Shame. Women who access mental or physical health treatment may not tell the provider about their substance use issues because they are ashamed of their behavior. Women are more likely than men to experience shame and embarrassment when they accept the need for substance abuse treatment (Schober & Annis, 1996). Also, women correctly feel that society has more negative attitudes toward female substance abusers than toward men, and in turn, they often internalize these negative attitudes.

These feelings of guilt and shame are magnified for women with children (Ehrmin, 2001). Substance abusing mothers hold the same high value about motherhood as non-abusing mothers. When mothers admit to a substance use problem, their view of themselves as “good mothers” is tarnished and their feelings of inadequacy and guilt are increased. These feelings of guilt are increased when they have to ask others for help with caring for their children in order to go to treatment.

Positive outreach through the media can decrease negative images of female substance abusers and may increase our understanding and respect for women who recognize their problems and seek help.

Self-reliance. Finally, we cannot underestimate the power of “self-reliance” as an internal barrier to treatment. Americans generally feel positive about their ethos of independence and place a high value on self-reliance. Women, as well as men, believe they should be strong enough to handle their substance use problems on their own, and are reticent to ask others for help (Copeland, 1997). Women also resist substance abuse treatment because of the mistaken belief that other people cannot solve their problems and substance abuse can only be solved on one’s own.

We need to help people understand that taking responsibility for one’s substance use problems often means allowing others to help.

Social barriers for women

Social barriers consist of the obstacles created by social institutions and culture, including: social support; parenting issues; and professional referral patterns for treatment.

Social support. Substance abusing women often reside in families and communities that are unable to provide the support they need to access and

engage in substance abuse treatment. They are afraid of what their employers, health care providers, friends and families would think about them; and often, they are correct. Women are more likely than men to encounter disapproval from friends and family regarding their participation in substance abuse treatment (Beckman, 1994b). The isolation from friends and co-workers that could ensue from disclosure of substance abuse problems may discourage some women from seeking treatment.

Substance abusing women also are often involved in intimate relationships with male substance abusing partners who encourage substance use or undermine treatment. These women are much more likely than non-substance abusing women to suffer from domestic violence. Engagement in substance abuse treatment may disrupt family relationships, and may result in serious physical harm.

Outreach efforts to the community may educate family and friends about the benefits of substance abuse treatment and may facilitate the entry of women into treatment.

Parenting. In general, society holds punitive attitudes toward substance abusing women. The stigmatization increases for pregnant and parenting women, resulting in increased barriers to treatment. These obstacles include difficulties providing child care, as well as concerns about losing custody of children.

Women substance abusers tend to express more concerns about their children and child-related issues than men (Ashley, Marsden & Brady, 2003). More often than men, these women have primary responsibility for caring for their children. Concerns about how to care for these children during treatment — regardless of whether the program is outpatient, day or residential treatment — become a barrier to treatment for women (Allen, 1995). Sometimes there is no one in the woman's family or community whom she trusts to care properly for the children, and sometimes there is no one willing to provide child care. Women are more likely than men to report that a lack of child care is a barrier to treatment (Grant, 1995).

Substance abusing pregnant women and mothers also fear losing their children if they reveal their substance abuse problems and seek treatment (Ehrmin, 2001). Foster care was designed to protect the child from risks presented by neglectful or abusive families. Children of substance abusing women are more likely to enter and remain longer in foster care than children of other families involved in the child welfare system (Columbia University, 1999). However, legal pressure also has been shown to be an incentive to treatment engagement, retention and completion. So, although the fear of losing one's children is barrier to disclosure of a substance abuse problem, the possibility of reunification may serve as a powerful reason for treatment.

More and better child care options combined with incentives for family unification may reduce these child care-related barriers to treatment.

Referral patterns. Women are more likely than men to be referred to treatment by family or friends (Beckman, 1994a). On the other hand, men are more likely to be referred to treatment by employers, physicians and the legal system, all of which are more knowledgeable about treatment options than word-of-mouth patterns. Learning about substance abuse treatment anecdotally can lead to the misinformation and the incorrect beliefs identified in earlier in this article.

However, these standard referral methods may not work for women. Physicians, for example, are less likely to correctly identify substance abuse in women than in men (Beckman, 1994a). Women who are partially or misdiagnosed with psychological problems are then referred to mental health care providers, many of whom also lack training and expertise in addiction diagnosis and treatment. The lack of expertise in the health care field regarding women's addiction issues, combined with women's internal sense of shame about their substance use, creates a powerful barrier to treatment.

It is imperative that health care providers be adequately trained to identify substance abuse in women.
Treatment program barriers. Given these internal and social barriers, it is impressive that women seek substance abuse treatment. However, once women recognize their problem and identify treatment as an achievable means of solving the problem, they still are faced with a number of barriers generated by treatment programs.

Treatment availability. Substance abusing women generally have lower levels of education and are less likely to hold full-time jobs than men (Greenfield, et al., 2007). They are less likely than men to have insurance or other economic resources to cover substance abuse treatment. Women often report they are unable to pay for substance abuse treatment (Allen, 1995). Although they may be more likely to be eligible for publicly funded programs than men, these treatment programs often have long waits for treatment slots to become available.

Innovative programs like telephone counseling, use of the Internet, or wait list activities may increase a woman's connection to recovery while she is waiting for formal treatment.

Treatment accessibility. Transpor-tation difficulties have been cited by a number of women as a barrier to their accessing treatment (Roberts & Nishimoto, 2006). Programs that are not located near public transportation are less accessible to substance abusing women, many of whom do not hold driver's licenses or own cars. This problem is compounded by the increasing costs of public transportation for women on very limited incomes. Like men, women also require treatment in the evenings and on weekends.

It's time to think out-of-the-box on treatment programs and to design ways to get treatment to the difficult-to-reach instead of expecting them to come to us.

Child-related needs and pregnancy. While affordability and accessibility affect men as well as women, the latter are more likely to be impacted by barriers related to their roles as mothers. As mentioned earlier, child care is a barrier to treatment for women. Most outpatient addiction treatment programs do not provide child care, and few residential programs admit women with children (Grella & Greenwell, 2004). However, women are more likely to complete long-term residential treatment when they have their children with them (Szuster, et al., 1996).

Women also are more likely to be reunited with their children when they are provided comprehensive services in addition to substance abuse treatment (Tracy, 1994). These services include: parenting skills; vocational training and assistance; housing assistance; psychiatric treatment; family planning; and services for the children's developmental needs. However, few programs have the resources to provide this wide array of services.

Pregnant women also require special services — such as methadone treatment for opiate-dependent women — which often are not provided by behavioral treatment programs. Other services, like prenatal and perinatal care, also are rarely provided.

In order to become "women friendly," addiction treatment programs must include the large group of women who are mothers and develop programs to meet their needs.

Therapeutic relationship. One of the most important aspects of therapy is the therapist-client relationship. A client's perceptions of negative staff attitudes may lessen her motivation to complete treatment (Roberts & Nishimoto, 2006). Addiction clinicians tend to be much more knowledgeable about substance abuse and treatment than most other people. However, they also live in society and may hold similar negative stereotypes as the rest of society, especially toward substance abusing women and mothers.

Likewise, some women may prefer a non-confrontational therapeutic approach (Copeland, 1997). Traditional substance abuse counseling confronts clients with their addictive behaviors and promotes the acceptance of labels, like "alcoholic" and "addict." While this approach may work very well with some clients, it may increase some women's feelings of shame and lower motivation for treatment.

Clinical supervision can help therapists identify their negative counter-transference issues and can provide a wide array of therapeutic approaches to use with different clients.

Breaking down the barriers

Although there are a number of barriers to treatment for women, they are not insurmountable. Treatment programs have begun the process of actively recruiting female patients by enhancing mixed-gender programs with services for women. Comprehensive women's programs also appear to attract substance abusing women to treatment earlier than they may have entered a mixed gender program (Beckman, 1994b).

These programs also appeal to women who are wary about traditional male-oriented treatment. Women and children programs, like the MatriArk Family Center and MaterLiber residential programs at Seabrook House, are especially attractive to mothers and pregnant women who may benefit from the specialized services for themselves and their children. Non-traditional treatment approaches, such as the Internet, motivational interviewing, and couples and family therapy, can increase a woman's motivation for treatment. Integrated treatment for co-occurring psychological and physical health conditions increases the likelihood that women will complete treatment.

As laudable as many of these advances in treatment may be, they are not sufficient to break down all of the barriers to treatment. While treatment program barriers modestly influence a woman's ability to access and complete treatment, internal and social barriers present more daunting obstacles. Public attitudes toward substance abusing women and mothers must change if women are to reduce their own feelings of shame and sense of denial. Health care providers must become better educated about how to identify and address substance abuse in women. These are not impossible goals. Public education campaigns have eliminated the stigma from cancer and have increased dramatically the numbers of people who are screened, diagnosed and successfully treated from this disease. We can achieve the same results for addiction in women.

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Allen, K. (1995). Barriers to treatment for addicted African-American women. Journal of the National Medical Association, 87(10), 751-756.
Ashley, O. S., Marsden, M. E., & Brady, T. M. (2003). Effectiveness of substance abuse treatment programming for women: A review. American Journal of Drug and Alcohol Abuse, 29(1), 19-53.
Beckman, L. J. (1994a). Barriers to alcoholism treatment for women. Alcohol Health & Research World, 18(3), 208-210.
Beckman, L. J. (1994b). Treatment needs of women with alcohol problems. Alcohol Health & Research World, 18(3), 206-211.
Columbia University. (1998). No Safe Haven: Children of Substance-Abusing Parents. New York: National

Center for Addiction and Substance Abuse at Columbia University.
Copeland, J. (1997). A qualitative study of barriers to formal treatment among women who self-managed change in addictive behaviours. Journal of Substance Abuse Treatment, 14(2), 183-190.
Ehrmin, J. T. (2001). Unresolved feelings of guilt and shame in the maternal role with substance-dependent African American women. Journal of Nursing Scholarship, 33(1), 47-52.
Grant, B. F. (1997). Barriers to alcoholism treatment: Reasons for not seeking treatment in a general population sample. Journal of Studies on Alcohol, 58(4), 365-371.
Green, C. A. (2006). Gender and use of substance abuse treatment services. Alcohol Research & Health, 29(1), 55-62.
Greenfield, S. F., Brooks, A. J., Gordon, S. M., Green, C. A., Kropp, F., McHugh, R. K., et al. (2007). Substance abuse treatment entry, retention, and outcome in women: A review of the literature. Drug and Alcohol Dependence, 86, 1-21.
Grella, C. E., & Greenwell, L. (2004). Substance Abuse Treatment for Women: Changes in the Settings Where Women Received Treatment and Types of Services Provided, 1987-1998. Journal of Behavioral Health Services & Research, 31(4), 367-383.
Roberts, A. C., & Nishimoto, R. (2006). Barriers to engaging and retaining African-American post-partum women in drug treatment. Journal of Drug Issues, 36(1), 53-76.
Schober, R., & Annis, H. M. (1996). Barriers to help-seeking for change in drinking: A gender-focused review of the literature. Addictive Behaviors, 21(1), 81-92.
Szuster, R. R., Rich, L. L., Chung, A., & Bisconer, S. W. (1996). Treatment retention in women's residential chemical dependency treatment: The effect of admission with children. Substance Use & Misuse, 31(8), 1001-1013.
Tracy, E. M. (1994). Maternal substance abuse: Protecting the child, preserving the family. Social Work, 39(5), 534-540.