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VOICES OF SUCCESSFUL WOMEN: GRADUATES OF A RESIDENTIAL TREATMENT PROGRAM FOR HOMELESS ADDICTED WOMEN WITH THEIR CHILDREN

BY

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A dissertation submitted to the Graduate Faculty in Social Welfare in partial fulfillment of the requirements for the degree of Doctor of Social Welfare, The City University of New York

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ABSTRACT

Voices of Successful Women: Graduates of a Residential Treatment Program For Homeless Addicted Women With Their Children

by

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This study presents factors associated with successful outcomes in a sample of clients of a residential alcohol and drug addiction treatment program for homeless women and their children. Quantitative methodology was employed on a sample of 65 respondents. The key treatment outcome indicated considerable success. Of the 65 clients in the project, 42 (64.6%) completed the program and moved to permanent housing. The variables positively associated with program completion included 1) being homeless for significantly longer periods of time; 2) having had prior treatment experiences; 3) having a partner with a history of substance abuse; and 4) having a father with a history of substance abuse.

Qualitative methodology consisted of interviewing 20 successful program participants to identify factors associated with their successful treatment experience and post-treatment maintenance of abstinence. A major finding of this study was the importance of their children in motivating respondents to seek treatment, and the continued importance of having their children present during treatment. Other factors associated with success included having a treatment program which was supportive to women's issues, and a knowledgeable, respectful staff.

The findings suggest a non-linear model that provides for the interplay of multiple forces set into motion by respondents' decision to stop drinking and/or using drugs, and to seek treatment at Casa Rita. The non-linear model includes critical components for successful treatment, challenges facing respondents post-treatment, and factors reported by respondents as helpful in the successful dealing with post-treatment issues.

PREFACE

Every person has different opportunities, where a million paths could have followed when young, but we followed that one which now seems inevitable to us, the one that memory says is the only one. But we have all wondered what would have happened to us if we had gone to Chicago instead of New York, or gone riding with a fellow named Smith the night he was killed in an automobile accident. These thoughts filled us with a real fear of what we might have done. Many have come so very close, so many times, to being fools, to being lost, to being dead, that we marvel that we have somehow blundered through to this day and year.--- Ray Bradbury

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This project was supported by enough people to fill Madison Square Garden. It would truly be impossible to name them all. Nevertheless, I wish to thank for their invaluable support Dr. Mike Smith, Dr. Mike Fabricant , and Dr. Charles Winick. I would also like to thank my dear and beloved family including Dr.Patricia Simko, without whose support I could not have completed this project, moreover, her endless patience and support really got me through this project. My friends and colleagues at

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CHAPTER 1

REVIEW OF THE LITERATURE

Introduction

There is a dearth of literature on homeless women with children who suffer from alcohol and drug problems. Women with alcohol and/ or drug problems are at great risk of for dropping out of addiction treatment. High rates of drop out and recidivism are prevalent among homeless women with addiction (North & Smith, 1994). Some studies (Bassuk and Rubin, 1986; Goodman, 1991) describe the severe pathology of homeless addicted women while others (Nelson-Zlupko, Kauffman, & Dore, 1995 ; Straussner, 1985) have suggested that program designs and interventions are inadequate. Frequently, addiction treatment is based on a male model that is counter productive for women and especially homeless women with children (CSAT,1994).

This study comes out of the findings based on a five year project of Women In Need Inc.(WIN) entitled "Casa Rita-Holistic -Family Based Treatment for Homeless Women and Children." The following key treatment outcome indicated considerable success; of the 65 clients in the project, 42 (64.6%) completed the program and moved to permanent housing.

The women who have completed the "Casa Rita" program have been treated for their addiction within the context of a program design reflecting gender and culture sensitivity, i.e., provision of childcare, non-confrontational approaches, non-punitive approaches to relapse, and the recognition that the dynamics of racism and gender play a role in addiction recovery. The overriding theory guiding the development of this program was based on a

"relational model" that viewed the importance of both women and their children benefitting and remaining in treatment together.

The program was designed to serve homeless drug-addicted women with children, and developed in response to the need for alternative treatment strategies for women that accommodate their children, provide supportive services, address issues of victimization, and employ gender and culturally sensitive methods. Women enrolled in Casa Rita were provided long term, comprehensive residential treatment with on-site childcare. Clients were expected to complete the program in a year to a year-and-a-half.

This study seeks to account for, and discover the personal characteristics, environmental factors and other factors that have contributed to these clients' recovering from addiction. The study will focus on relationships, strengths, and environmental factors from the client's perspective that contributed to their successful outcomes.

In depth-interviews with a sample of 20 women who have participated in post-treatment follow-up interviews have been conducted in order to understand 1) what it takes to sustain sobriety; 2) what the obstacles are to maintaining drug and alcohol-free and to what extent these factors are individual, relational, and/ or environmental; 3) which relationships are sources of support; 4) which were the important aspects of treatment.

The data analysis of the client's perspective about treatment and post-treatment experiences will provide an in-depth understanding of the factors that contributed to these women's recovery from addiction. The analysis of the data has led to recommendations for existing and developing treatment programs for women with children, as well as for other women dealing with the recovery of addiction.

The Basis of Concern

Scientific evidence indicates that certain individuals are at greater risk of disease, dysfunction and death as a consequence of alcohol and other drug use and abuse than are others. Women, and in particular, homeless women with children, who live at or near the poverty line are among the most vulnerable of these. For them, substance abuse, and the biological, psychiatric, psychological and socio-economic co-factors of substance abuse may be severe (CSAT, 1994).

Due to both individual and structural factors, alcohol and drug -abusing homeless women with children may be unable to access and engage in treatment. Individual factors contribute to this inability, and include psychological problems, such as depression and anxiety (Turnbull & Gomberg, 1990), high levels of guilt and shame (Underhill, 1986), high rates of trauma (Forth-Finnegan, 1991) and rigid family roles (Dulfano, 1985). These factors help explain not only low rates of entry into treatment, but also correspondingly low rates of retention, and completion of treatment (Blume, 1990). Fears of losing custody of children, and resistance of family members who depend on them for daily supportive functions are often obstacles facing women when they enter treatment (Reed, 1981). In addition, the psychological features of addiction, including defense mechanisms of denial and rationalization, keep women from entering the addiction treatment system (Rosenbaum, 1997).

Structural factors also operate to deter women from successful treatment for addiction. In fact, addicted women present a vast array of special needs and requirements,

in addition to "traditional" treatment for substance addiction, when they enter a program. These needs flow from gender-related factors, such as the unique physical vulnerability of the female in society and especially in poor neighborhoods. Most importantly, women's unique needs stem from the fact that they are the primary caretakers of children, with all the multiple and exigent demands of this role (Goldberg & Kremen, 1990). Critical health and mental-health problems, injuries resulting from histories of physical and sexual abuse; child-care and development; parenting skills development; child abuse and neglect prevention, transportation and safe housing are aspects which represent the complexity and multifaceted nature of the problem of addiction in the population of women with children (Lewis, Haller, Branch & Ingersoll, 1996; Smith & North, 1995).

It is important to note that substance abuse programs were designed by men, and for men. Their approaches have been informed by research conducted on male substance-abusing populations (Nelson-Zlupko et al., 1995). Thus, most programs were designed without consideration of the addicted woman and her specific needs. For example, programs were designed without child-care facilities and pregnant women were usually excluded (Chavkin, Walker & Paone, 1992). Most addiction treatment programs still do not provide child-care or, in the case of residential facilities, are not equipped to accept women with their children (Zankowski, 1987). Often women are placed in the position of having to temporarily relinquish responsibility for and custody of their children if they choose to receive help for their addiction.

Intervention techniques are also based on a male model. For example, aggressively confrontational techniques and a highly structured program are still the norm, yet these are

notoriously unsuccessful when applied to females (Nelson-Zlupko et al., 1995). Confrontative techniques are based in part on the theory that men blame others for their problems and need confrontation to break through their denial. But for women who blame themselves, these strategies have the effect of driving women away, since they employ harsh and judgmental techniques that reinforce the woman's feelings of shame and guilt (Reid, 1985). Many women who have accessed these treatments have reported negative past experiences and unsympathetic treatment providers as reasons for not continuing in treatment (House Select Committee on Children, Youth and Families, 1990). When women do seek treatment, they also face strained substance abuse treatment agencies that lack the capacity, financial resources, or appropriate family-centered approaches to effectively meet their multiple treatment needs (CSAT, 1994).

Since the treatment needs of this population were inadequately foreseen and not planned for, drop-out rates are high. Other structural factors that influence treatment drop-out include impoverished living environments characterized by high rates of drug use, crime, unemployment and family violence. Poor women often do not have the resources to move out of these environments and cannot avoid these "high risk environments" (Lewis, Haller, Branch, & Ingersoll, 1996).

In sum, homeless women with children who have alcohol and other drug problems are in dire need of treatment, but frequently do not seek it; they have limited access to treatment, and on entry are usually not provided with the comprehensive continuum of care designed to address the multiple needs they and their children face (CSAT, 1994; Smith & North, 1995). In addition, they have a very high drop-out rate (Smith & North, 1995).

In a report issued by the New York City Commission on the Homeless, the critical need for substance abuse treatment for homeless families was highlighted (Cuomo, 1992). The report found that 27% of 331 homeless families tested positive for either cocaine, THC, alcohol, opiates, or amphetamines. 18% of families surveyed reported using drugs during the past year; of them, 85% said they were willing to participate in drug rehabilitation (Cuomo, 1992). Since 1992 there have been five programs in New York City which provide addiction treatment in a family shelter setting. However, these programs have a limited capacity to serve the numerous families in need of treatment, since together they can treat only 190 families city-wide.

Moreover, not all these slots are being filled with homeless families in need of addiction treatment. NYC homeless policies of diversion (1997) reduced the number of poor families eligible to enter the homeless system. This decrease led to these programs experiencing budget deficits, as there were fewer payments received. In response, the specialized family shelters with addiction treatment services began accepting any homeless family, irrespective of a substance abuse problem. This was an attempt to reduce the budget deficits created by vacancies (Emergency Alliance, 1997). Thus, in actuality, many of the available residential treatment slots are used by homeless families who are in need of housing but not of treatment. Data from August 1997, indicates that there were 4,790 sheltered homeless families (Barrios-Paoli, 1997). If the 27% figure cited by the Cuomo report is generalizable, this means that 1,294 of these families would test positive for substance use. Clearly, the available treatment slots leave many homeless families without access to addiction treatment in family shelters.

There has not been any outcome evaluation or systematic descriptive data on the demographics or characteristics of the families being served in any of these family shelter programs. The paucity of research on the population of homeless women and children in addiction treatment has left many questions regarding which families are being served; what residential-based strategies and continuing care services are most useful; and whether there are any predictors of outcome. Moreover, there have not been any studies that have included the perspective of women in describing what they think contributes to their treatment success.

Most experts working with addicted women with children agree that comprehensive services, including children's services, are essential in treating this population (Finkelstein, 1990; Reed, 1985; CSAT, 1994). Amazingly, there has only been one published study comparing homeless mothers with their children in a comprehensive residential treatment program with an outpatient program (Smith & North, 1995). The most salient finding of that study concerned the low participation and retention rates: a 15% no-show rate and, among participants who actually started the program, an 85% dropout rate (Smith, North & Fox, 1995). These rates are consistent with anecdotes of directors of addiction programs throughout New York City: "homeless women with kids don't come, or if they do, don't stay" (AnyCap, 1996).

Casa Rita, a shelter-based treatment program operated by Women In Need, Inc. is one of the five city-wide programs that provide addiction treatment in a family shelter. Since it is a relatively small residential program of 16 families, it has been able to accept only homeless families who actually have addiction problems. In 1992, this program received a

five-year grant from the Center of Substance Abuse Treatment (CSAT) to provide a holistic family-based treatment program.

During the CSAT grant period, I was the Co-Principle Investigator and supervised the program director and, for six months during the project, I was the acting program director. From this standpoint, I am very familiar with the program's design, implementation, treatment program and evaluation. I will report the evaluation findings based on existing data collected at base-line and upon follow-up. The evaluation findings have indicated two significant relationships and two trends toward statistical significance between base line variables and program completion. The clients who completed the program: 1) were homeless for significantly longer periods of time, 2) had partner with a history of substance abuse, 3) were likely to have more than two previous treatment episodes, and 4) tended to have a father with a history of substance abuse. These variables are associated with program completion however, in and of themselves do not fully illuminate the nature of the relationship.

This study, by examining both qualitative and quantitative data, seeks to fill the gap in knowledge about how these variables, characteristics, relationships and experiences impact on women with children who become and remain sober post-treatment. The focus of the study is on the personal characteristics, environmental factors and other factors which impacted on successful treatment outcomes. It is my hope that I will capture the essence of experience of successful clients of this program, and give a voice to the women themselves, and in this way, add to the knowledge of what it takes to successfully maintain treatment benefits.

History of Homeless Women and Children

The history of homeless addicted women is complicated, since there is a wide variation in the definition of "homelessness" which plagues researchers and historians (Burt,92; McChesney, 1995). In the United States, family homelessness was treated as an acute problem during the Great Depression of the 1930's, and most recently, during the middle of the 1980's (Hoch & Slayton, 1989). For example, in San Francisco, the number of families using emergency shelters increased from 6,902 in 1929 to 55,789 in 1932 (Hoch & Slayton, 1989). In 1987, a widely respected national study by Burt and Cohen (1987) estimated that 500,000 to 600,000 people were homeless, and 23% of these were members of homeless families. That translates into an estimated 115,000 to 138,000 people who are members of homeless families (McChesney, 1995). During the 1980's and 1990's, homeless women with children have been the fastest growing population among the increasing population of homeless people (Institute of Medicine, 1988; Rossi, 1994; Burt, 1992). In 1995, homeless families with children comprised approximately 36.5%, and single women 14%, of the homeless population (U. S. Conference of Mayors, 1995). Homelessness has dramatically increased during these recent historic times of economic upheaval or recession (Hoch and Slayton, 1987).

The scope and magnitude of homeless women with children have been well documented, despite methodological limitations of defining homelessness (Stefl,1987). For example, definitions of homelessness have occasionally but not consistently included doubled-up families and those residing in battered women shelters and jails. Counting

homeless people is usually done by counting the number of people in an emergency shelter and in public spaces not designed for shelter on a given night (Van Ry, 1993). Despite this limitation, recent studies suggest that the demographic characteristics of today's homeless differ dramatically from the past, when the homeless population was dominated by elderly, white, unattached males. The diversity and heterogeneity of today's homeless have been classified based on personal characteristics as well as life history. Stefle (1987) describes how types and subtypes of homeless persons demonstrate the complexity and multifaceted issues of homelessness. Some of the sub-groups have included: the chronically mentally ill, chronic alcoholics, street people, situationally distressed, homeless women, and rural homeless. The situationally distressed typically includes homeless women with children, while they often are counted as part of other groupings as well. The heterogeneity of the homeless population and the complexity of the issues involved suggest a need to look more carefully at subgroups of the homeless population (Banyard & Graham-Bermann, 1995).

It has only been in the past two decades that homeless families, most of them single-parent and female-headed, have emerged as a visible and disturbing phenomenon (Rog, Holupka, & McCombs-Thornton, 1995). Homeless women with children in New York City were initially made public in 1970. The Daily News wrote about a social service worker who put a family in the Waldorf Astoria Hotel and thereby focused attention on the problem of thousands of families residing in welfare hotels (Leavitt, 1981). In response, the NYC Housing Authority made a commitment to create a facility which would no longer make the City dependent on welfare hotels (Leavitt, 1981). New York City's current family shelter system known as Tier II shelters has its roots in this earlier response. Tier II shelters are

family shelters that require a private room for a homeless family. A Tier 1 shelter is a congregate shelter, where beds are arranged barrack style, with no privacy for families. In 1988, the New York State Department of Social Services promulgated regulations for family shelters and made this the distinguishing feature between a Tier 1 and Tier II shelters. Since 1988, the regulations have been expanded, requiring services and service plans, procedures for discharges and family rights.

Typically, researchers have looked at factors that are important descriptors of homeless single adults. There are three major sets of problems associated with extreme poverty and homelessness: psychiatric disability, substance abuse and a prison history (McChensey, 1995). What we know about homeless women with children has come primarily from a small number of research studies focusing on these sets of problems (Bassuk & Rosenberg, 1988; Bassuk, Rubin, & Lauriat, 1986; Knickman & Weitzman, 1989; McChensey, 1992; Van Ry, 1993; Weinreb and Rossi, 1995). These studies are primarily descriptive and have been remarkably consistent in many of their findings, especially those related to demographics (Rog et al., 1995). Most of the studies describe the typical family as headed by a single woman, in her late twenties and with two children.

Methodological issues common to studies of homeless families prohibit meaningful generalization or comparisons across studies. Studies have varied significantly by focus, design, method, definitions of homelessness and family unit (Robertson, 1991). Almost all studies have been cross-sectional, over-representing persons who have been homeless longer.

Studies which have compared homeless families with housed poor families found that homeless women with children lack social support in time of need and have a greater

frequency of drug, alcohol and psychiatric problems (Bassuk et al., 1988). In addition, 40% reported that their health was only fair or poor, while 90% of housed women reported good or excellent health (Burt & Cohen, 1989). Homeless mothers were significantly more likely to be physically and sexually abused as children (Shinn, Knickman, and Weitzman, 1991). Another study by Goodman (1991), however, found a relatively high level of child abuse for both groups, with no significant differences between poor housed and homeless women. Three of four projects that compared the rate of psychiatric hospitalization of homeless mothers with that of housed mothers reported rates from two to four times greater for the homeless group (Bassuk & Rosenberg, 1988). Again, Goodman (1991) found no difference. Knickman & Weitzman (1989) describe risk factors associated with mothers becoming homeless; these include pregnancy, previous shelter use and substance abuse.

Homeless Causal Factors: Structural Limits vs. Personal Characteristics

Structural explanations for the increase in the homeless population have included; the fiscal crisis of the late 1970's and early 1980's resulting in the shortage of low income housing (Hayes, 1982), and the increases in the poverty and unemployment rates (Devine & Wright, 1997) and the de-institutionalization of the psychiatrically disabled (Rochefort, 1986). The effects of the fiscal crisis resulted in a lack of profit and few government subsidies for developers of low and moderate housing. Between the late 1970's and early 1980's, there was a 30% decline in the number of low income units in 12 of the 20 largest U.S. cities (Wright & Lam, 1987). The poverty rate over the same time frame continually

increased from 35 million in 1983 to 40 million in 1993 (Devine & Wright, 1997). In 1987, women headed 16% of the nation's 64 million families; 51% of the families living in poverty were headed by a woman (Abramovitz, 1988). The increasing poverty among single women with children in the United States reflects that they have become the largest growing segment of the of the homeless population (Bassuk et al., 1988). In the 1970's over 250,000 patients confined to mental hospitals were released to community care without provisions for communities to handle their psychiatric and housing needs. Communities were experiencing the loss of low-income housing and single room occupancies (SRO's), while many psychiatric patients were being discharged to the streets (Rochefort, 1986).

Individual explanations of the homeless have been attributed to various personal and psychological disabilities of the homeless themselves, especially mental illness and substance abuse (Devine & Wright,1997). Studies have suggested that people become homeless because their disabilities cause them to become disaffiliated from family, friends, and work (Baum & Burnes, 1993; Dolbeare, 1989). The experience of being homeless is not a random event that is independent of individual characteristics and experience (Robertson, 1991). Particularly, in the context of poverty and high housing costs (Dolbeare, 1989), serious personal and family problems (Robertson, 1991), psychiatric factors (Hopper, 1990), and addictions (Devine & Wright, 1997), can make an individual less able to compete for scarce resources such as low-cost housing or employment (Hopper, 1990; Wood et al., 1989).

History of Women and Addiction

The terrifying image of the drunken woman goes back to ancient Greece. In the myth of Baccantes, when she becomes intoxicated, the woman murders men, including Orpheus. This tale symbolizes men's fears that women who are out of control will overpower and destroy them (Sandmaier, 1980). In ancient Rome, a woman was forced to kiss all her male relatives, to see if she had been drinking wine. Execution was a possible punishment (NIAAA, 1980). As recently as 1988, homeless women abusing alcohol and crack were perhaps the most feared and punished in society. Enormous media coverage produced images of homeless, black, crack smoking women as violent and child killers (Hinds,1990). The country responded by passing the most severe anti-drug laws since prohibition (Mustro, 1997).

Information on patterns of drug and alcohol use by women prior to the late 18th century is meager. During that time, the drug most used by women was alcohol (Worth, 1991). Throughout history, depending on the historical time and treatment of women, those women who have suffered from alcoholism and drug addiction have either gone unnoticed, or their problems have been exaggerated (Lender, 1985). They have either been demonized or rendered invisible. Thus, an understanding of women's roles and status in society is necessary to understand their alcoholism and substance abuse problems.

During the 18th century, in London, "gin epidemic" British slum mothers were accused of drinking too much gin and causing the death of their young (NIAAA, 1980). In fact, poor nutrition and disease were major factors in these children's deaths. Nevertheless,

the mothers were blamed. It is unclear how many children died due to their mother's drinking (Sandmair, 1981). However, it was clear that some of these women did have problems with alcohol. Women in lower socioeconomic classes abused gin, while middle and upper-class women obtained legal prescriptions for opium and alcohol tonics (Worth, 1991).

Technological and chemical advances in the 1800's made the most powerful ingredients in opium available in pure, cheap form. Morphine, a derivative of opium, and codeine were easily accessible over-the-counter drugs and used for a variety of different ailments. Thus, heroin, morphine, and codeine were associated with white Americans, while the introduction of cocaine in the late 1800's became associated with the "Negro" problem (Musto, 1997). However, cocaine was consumed by American women mostly in patented medicines (Chitwood, 1985). The use of cocaine was not only promoted to improve health and vitality, it was also viewed as a cure for morphine addiction (Grinspoon & Bakalar, 1976). In the late 1800's, American women addicted to legal "remedies," alcohol, opiates, analgetics and coca products, outnumbered men by two-to-one (Terry & Pellens, 1928). Interestingly, current research indicates that women are still more likely to abuse licit drugs while men are more likely to be abuse illicit drugs (Corrigan, 1987)

In nineteenth-century America, alcohol abuse and opiate addiction by women was a problem, although it was not easily identified. There was a stigma attached to women's drinking which was perceived as offending cultural expectations of female behavior (Worth, 1989). In the United States during the late part of the 1800's, women were prescribed alcohol and narcotics for medicinal reasons, including nursing (Clemmons, 1986). Interestingly, women were encouraged to use patent medicines with a high alcohol content and morphine

for relief of their menstrual problems and pain in childbirth (Sandmair, 1980). By the early 1900's, twice as many women as men were addicted to alcohol and narcotics due to obtaining legal prescriptions sold for medicinal purposes (Clemmons, 1986).

Ironically, despite these women's problems with alcohol and narcotics, the Woman's Christian Temperance Union movement of the late 1800's focused on a national prohibition, which appeared to be the only solution to the problem of alcoholic husbands. There may have been some few unfortunate women who were public "drunkards," but for the most part they were not considered a social problem like their male counterparts (Papchriston, 1976). By creating pressure on women who drank excessively to move away from consuming alcohol, the Temperance Union movement contributed to women's reliance on prescription medicaments and thus the invisibility of their substance use. These prescriptions included alcohol and morphine, a tonic and drug whose use was easily hidden, and thus did not offend the social role or cultural expectations for women (Papchriston, 1976). Interestingly, by forging alliances with the Prohibition Party, the Temperance Union effectively transformed alcohol consumption from a moral issue to a political issue (Blocker, 1989).

Throughout prohibition (1919-1933) more than 50,000 women were involved in some aspect of bootlegging, and many women owned and operated their own illegal speakeasies. During this time, women involved with alcohol were viewed as immoral, and some physicians recommended hysterectomies for alcoholic women who would not respond to treatment (Sandmaier, 1980). These "remedies" reflected societal accusations of women as both sexually deviant and neglectful of family, accusations that were in particular attributed to addicted women. These attributes were so distant from public expectations of

women's behavior that society could account for them as extreme moral deviance (Lender, 1986). During this same period the explanation of addiction as a disease was gaining acceptance; however, for women who drank, myths and moral overtones still prevailed (Saleeby, 1986).

The beginning of the twentieth century was a time of radical social change for women. The suffragette movement and the right to vote brought increased social and political independence. Standards of behavior were relaxed compared to previous times and "modern" methods of birth control, introduction of psychoanalysis, pursuit of careers, access to education, divorce and liquor set the social stage for women to experience the same "freedoms" and consequences as men (Clemmons, 1986). However, women continued to face an imposed double standard that has subjected them to harsher judgements, criticism, and greater societal pathologizing of their behavior than men (Royce, 1986). Society's concern for women with alcohol and substance abuse problems has focused on the role they play as wife and bearer of children, not on the needs of the women themselves. This problem has been cast in the moral arena (Roth, 1991).

During the 1960's and 1970's, while the women's movement directed attention to many women's issues, it paid little or no attention to alcohol or drug problems as a critical issue for women (Roth, 1991). Nonetheless, in the 1970's, a Gallup poll revealed that the number of women in the United States who drank alcohol jumped from 45% to 66% from 1939 to 1978 (NIAA, 1980). Women accounted for two -thirds of psychoactive drug users in the 1970's (Wesson, Carlin, Adams & Beschner, 1978). In 1975, the United States Congress passed legislation requiring states to provide prevention and treatment programs

for women. During this time, fetal alcohol syndrome and sexual promiscuity were issues that received considerable attention. Since fetal alcohol syndrome involves infants, the problem of female alcoholism continued to be viewed as a moral rather than a sociomedical issue- despite moves toward the latter in other arenas, such as cancer (Clemmons, 1986).

According to the latest assessment of the impact of alcohol and substance abuse problems on women by the National Center on Addiction and Substance Abuse at Columbia University (1996), in recent years, women are increasingly likely to abuse alcohol at the same rate as men. In addition, women are more vulnerable to the immediate and long-term consequences of alcohol abuse. For example, they metabolize alcohol differently, get drunk faster, become addicted more easily and develop cirrhosis of the liver more readily (NIAAA,1990). A significantly greater percentage of alcoholic women than men die from alcohol related accidents, violence, suicide, and HIV/Aids (Califano, 1996). Women develop health- related problems associated with alcohol sooner than men. The gap in prevalence is closing between men and women, however, for women, the consequences of addiction are often more grim.

Extent and Distribution of the Alcohol Problem

Alcohol is the most commonly abused substance by the general population and by women as well (CSAT, 1994). The trends in abuse of alcohol by women are not encouraging. For example, the 1993 National Household Survey on Drug Abuse (NHSDA), based on self reported alcohol use, found that 2.5 million women drank at least 60 drinks per

month -- the measure of heavy drinking established by the National Institute of Alcohol Abuse and Alcoholism. But that measure is based on the male standard for heavy drinking: two drinks a day (Wilsnack, 1995). A study that applied the mental health diagnostic criteria to drinking related behavior among adults concluded that 4.5 million women and 10.6 million men abuse or depend on alcohol (Grant, Haford, Dawson, Chou, Dufour, and Pickering, 1994).

The NHSDA (1993) study analyzed drinking problems among women according to their economic status, education, race, ethnicity, employment and marital status. It found that both men and women with lower incomes are likelier to drink heavily than people with higher incomes. While white women are more likely to drink than African-American women, their rates of heavy drinking differ only slightly. Black women tend to be concentrated at the extremes of either abstinence or heavy drinking. Unlike white women, heavy drinking by black women does not decrease as their income increases. Heavy drinking rates decline as women attain higher education, and working women who are unemployed are more than 400% likelier to drink heavily than employed women.

Marital status is another complicating factor. Women who have never been married are likelier to drink heavily than married women. Widows are three times more likely than married women to drink more heavily (Gomberg, 1995). The impact of divorce is more complex. When women with alcohol problems divorce, their drinking tends to subside, especially if their partner is a problem drinker. But when women without alcohol problems divorce, their drinking often increases to problem levels (Wilsnack, 1995). Thus, it would appear that woman divorcing seek to both distance from problematic behaviors from within

the marriage, but they also appear, when alcohol-use is not an established problem, to use it to cope or self soothe.

Actual Societal Responses

As discussed, the Temperance movement and the passage of the Volstead Act in 1920, which prohibited alcohol, were major societal responses to alcohol. By outlawing alcohol, the response to alcohol problems was to deal with it as a crime. Both men and women with alcohol problems were jailed and women were often ostracized and, at best, placed in mental institutions for the insane (Morgan, 1981). Women were typically given longer jail time than their male counterparts (Worth, 1991). Consequentially, the illegal production and distribution of alcohol contributed to the development of organized crime (Musto, 1997).

During the early 1900's legislators, professionals and the public, faced with what they perceived as social breakdown associated with alcohol and drugs, adopted federal laws to control the distribution and consumption of drugs by; limiting opium imports, controlling international traffic in narcotics, requiring contents and percentages labeled in popular remedies if they contained opiates, cannabis, cocaine or chloral hydrate (Mustro, 1997).

In 1935, Alcoholics Anonymous (A.A.) was founded, although few women participated. This fellowship marked the beginning of the social movement to view alcoholism as a spiritual, physical and mental disease (Cohen & Levy, 1992). In 1944, the U.S. Public Health Service labeled alcoholism as the nation's 4th largest public health

problem. This led to alcohol prevention efforts by the National Council on Alcoholism and Chemical Dependencies, under the leadership of Marty Mann, a New York socialite who was one of the first women members of A.A. Twenty-one years later in 1956, the American Medical Association recognized alcoholism as a disease. Thus, treatment became available in state psychiatric hospitals. Throughout this period, however, very little attention was given to the woman alcoholic.

During the 1970's, public attention was focused on women with alcohol problems. One reason for this increased attention was the fact that more middle-class women were seeking treatment (Roth, 1991). In 1978, the United States Senate held hearings on women and alcohol, two years later doctors identified the Fetal Alcohol Syndrome (FAS). Until this time, physicians encouraged pregnant women to drink moderately during pregnancy to remain serene (Cohen and Levy, 1992). The Congressional hearings led to legislation requiring states to provide and funding them for prevention and treatment programs for women. From 1976 to 1981, 40 grants were awarded for treatment programs for women, by the National Institute on Alcohol and Abuse. In 1981, with the advent of block grants, the NIAAA role changed to funding research initiatives in lieu of service grants. Thus, many of these programs were closed at that time. In 1988, the Congress passed a bill for states to set aside 10% of the block grant money for prevention and treatment services for women. Unfortunately, many states have not used the funds in a manner consistent with the legislation (Roth, 1991). States did not necessarily spend their set-aside funds on new and expanded prevention and treatment services for women, but rather, in the face of dwindling government support, spent the money on preserving existing services.

The growth of treatment programs proliferated throughout the 1980's and 1990's. Many alcohol and drug treatment programs opened around the country and were, in large part, designed to treat white males. At the same time, many coeducational, hospital-based programs opened, including private facilities, serving those with insurance coverage or with the economic resources to pay. Unfortunately, there was again little sensitivity to the alcoholic woman (Roth, 1991).

During the 1990's, societal responses to the woman alcoholic and substance abuser have been mostly focused on her children (Murphy & Rosenbaum, 1999). The Center for Substance Abuse Treatment (CSAT) has attempted to take a leadership role in the prevention and treatment of alcohol problems in women. Interestingly, the Women and Children's Branch of CSAT only funds programs for women when children are involved. They have provided funding for pregnant and postpartum women, and women with children in residential treatment (CSAT, 1993). In contrast, at the other extreme, some states have attempted to criminalize pregnant women for drinking alcohol beverages. Women alcoholics in the 1990's have little more access to treatment than they did in the 1940's. They continue to deal with society's harsh judgement which reinforces guilt and shame, making access to the few treatment facilities designed for them even more difficult.

Nature and Significance of the Research

Research on women and addiction remains one of the most neglected areas in the field of addiction studies (Corrigan, 1980). A survey of the research literature on women and

addiction reveals only 28 studies between 1928 and 1970 (Sandmaier, 1980). Much of what is known about addiction is based on research dealing with male subjects which is then applied to women (Cohen and Levy, 1991).

The first published study in 1937 on women and addiction focused on the psychopathology of women's personality traits compared to men's. An important observation was the association of excessive drinking or substance abuse with a definite life situation. Another major component of the study was that the diagnosis of alcoholism or substance abuse was considered more deviant for women than for man (Curran, 1937).

Throughout the 1940's and 1950's the incidence of alcoholism in women was unknown and there were conflicting findings by Keller and Efron (1955). This study proposed and contradicted whether the incidence of alcoholism in women was increasing. Since that time more sophisticated technology has allowed researchers to more accurately cite the incidence of alcoholism among women. Califano (1996) cited that in the United States, there were 4.5 million women who are either alcoholics or alcohol abusers.

Jellinek (1952) describes alcoholism in men as a medical disease with specific symptoms, having progressive phases, and being fatal. This disease model is applied to women and is well accepted in the addiction field. While the application appears legitimate, no specific study has ever documented its occurrence and progression with women.

Corrigan (1980) studied alcoholic women in treatment and found that they, like other women, have internalized society's expectations of them. Additionally, this study underscored the lack of societal change in attitudes toward alcoholic women. Much of society continues to view women's alcoholism as a moral problem and judge women

alcoholics harshly.

Significantly, Wilsnack (1995), reports that 65% of female alcoholics, compared with 44% of male alcoholics had a secondary diagnosis. For women alcoholics, major depression was also present in 19%; phobic disorder was diagnosed in 31%; and panic disorder in 7% of the women. In comparing the rates of mental disorders in women with alcohol-related diagnoses to women in the general population, the rates of these second diagnoses were considerably higher in the alcoholic group. The major depression rate was nearly triple that of the general female population, and the rate for phobias nearly double (Wilsnack, 1995).

Studies indicate that about 6% of alcoholic women have a child with Fetal Alcohol Syndrome. Rates of FAS are much higher among African American and Hispanic alcoholics who live in poverty, have lower levels of education, and get late or no pre-natal care than among white alcoholics who have higher incomes and levels of education, and who get timely pre-natal care, even though the rates of heavy drinking are similar (Bingol, Schuster, Fuchs, Iosub, Turner, Stone, and Gromish, 1987).

Homeless Women with Children and Substance Abuse

The prevalence of homeless mothers abusing drugs or alcohol varies widely in studies attempting to assess this factor. Surveys in different cities showed that about 33-45% of homeless women are substance abusers of crack cocaine and to a lesser extent, heroin and alcohol (Joseph & Paone, 1997). However, relatively low rates of 8-9% have been reported

among a sample of homeless mothers in Massachusetts during 1985-1986 (Bassuk et al., 1986). In 1990-1992, a study in Baltimore reported that 50% of their sample of homeless mothers were abusing a drug (Fisher, Breakley, Nestadt, 1992). In data compiled by New York City Commission on the Homeless, the percentage of families testing positive for drug use in privately run shelters (Tier II) was 26%, and 34% for city-run, non-tier II facilities for homeless families (Cuomo, 1992).

Studies do suggest a high prevalence of alcohol and drug problems among homeless women with children compared with other poor women with children (Robertson,1991). For example, in the Bassuk et al. (1988) case control study of poor, female-headed families in Boston, higher alcohol and other drug problems were reported for homeless mothers compared with poor, housed mothers (16% compared with 6% respectively, on the basis of structured psychiatric interviews and applying the Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition Criteria, Knickman and Weitzman (1989), in a comparison of homeless parents requesting access to New York City shelters with housed parents receiving public assistance, stated that 4.8% vs. 1.1%, respectively, reported recent, personal substance abuse problems. In this study, detoxification treatment for alcohol or drugs was a significant predictor of homelessness in a multivariate model. In Los Angeles, homeless mothers reported more alcohol or other drug use than did poor housed mothers (43% vs. 30%; Wood, Valdez, Hayashi & Shen, 1990). The difference in drug use stemmed from a higher prevalence and more frequent use of crack among homeless mothers 25.3% of homeless mothers used cocaine compared with 16.8% of housed mothers, and cocaine was frequently used by 8.7% of homeless mothers compared with 3.1% of housed mothers

(Robertson, 1991; Wood et al., 1989).

Parental substance abuse is thought to be the primary factor in the greatly increased rates of children entering the foster care over the past decade (Dore, Doris, & Wright, 1995). In a study comparing substance abusing parents involved in protective services with other parents, parents with documented substance abuse were more likely to be repeat offenders with regard to child abuse and neglect, to fail to follow through with court ordered services and to lose custody of their children (Murphy et al., 1991) Mothers were more at risk of homelessness due to their loss of income, including rent subsidies, when their Aid to Families with Dependant Children (AFDC) benefits were terminated. During the 1980's and 1990's, when the rates of women and children were the fastest growing sub-population of homeless, another sub-population of single women with children in foster care were among the ranks of the homeless (D'Ercole & Struening, 1990).

Crack was reported to be the number one illicit drug used by women of child-bearing age (Berger, Sorenson, Gendler, & Fitzsimmons, 1990). As a smokable form of cocaine, crack is readily available at a low cost. The route of admission and the purity of the drug seem to account for the pervasive use among women. Smoking the drug, in addition to providing a rapid intense high, appears to the user to be less dangerous and less invasive, like a cigarette (Zimmer & Schretzman, 1990). The user experiences a sense of euphoria and power. These experiences are welcome in a daily reality of poverty and homelessness.

In 1988, maternal drug use and homelessness were the two primary reasons for boarder baby status in New York City (Chavkin, 1990). During the nine year period from 1980-1989, annual complaints of child abuse rose from 18,000 to 66,000, an increase of

266% (Joseph & Peone, 1997). Califano (1997) predicts that by 1998 women with chemical dependency problems and hundreds of thousands of their children will become impoverished and therefore likely to become homeless.

Woman in Substance Abuse Treatment

Most studies of addicted women are etiological; that is, they focus on demographics, diagnosis, or other descriptive attributes (Schmidt, Klee, & Ames, 1990; Turnbull & Gomberg, 1994). Women who suffer from chemical dependency are likely to suffer from a variety of other emotional problems, especially depression, both before and after the onset of their addiction (Blume, 1997). Studies have indicated that many addicted women who enter treatment experienced child abuse (Winfield, George, Swartz, & Blazer, 1990), suffer from depression (Helzer and Pryzbeck,1988), anxiety (Ross, Glasser, Stiasny, 1988; Windle, 1995), post-traumatic stress syndrome (Saladin, Brady, Dansky, and Kilpatrick, 1995). Other psychiatric diagnoses found in chemically dependant or abusing women include bulimia (Ross et al.,1988) and borderline personality disorder (Turnbull & Gomberg, 1988). Interestingly, many of these descriptions are similar to those of homeless women, generally.

There is still a dearth of studies that include client sex as a variable. It is therefore impossible to know how gender contributes to outcomes. There are also very few studies that link client characteristics with treatment outcomes (Ridlen, 1997). Williams and Roberts (1991), sought to determine whether demographic and psychological functioning would predict length of stay in treatment of 136 chemically dependant females treated in a

residential therapeutic community. The most significant finding of this study was that women with less depression tend to remain in treatment longer.

Odyssey House was the country's first program to provide treatment to drug dependent women together with their young children in residential treatment. Winick and Evans (1997) reviewed the literature on the relationship of demographic, psychological and family composition on predicted length of stay. In this study, the variables of most predictive power in descending order were age, family composition and education. The older the woman, the more likely she is to stay longer. Having a child with a woman in the residence contributed to a longer length of stay. Education, in terms of the number of years was positively correlated with length of stay (Winick et al.,1997).

Interestingly, two other studies of women with children in treatment for addictions reveal similar demographics. In both cases, the typical woman is single, poor, unemployed, in her late twenties and with an average of two children (Hughes et al., 1995; Faupel and Hanke, 1993).

Empirical Studies of Homeless Women with Children in Treatment

With the rise of numbers of homeless people and the focus of attention on the problem of homelessness in the 1980's, the National Institute of Alcoholism and Alcohol Abuse (NIAAA) began to look more carefully into treatment issues specific to the homeless (Shane, Ridgley, Sherman, O'Neill, Goldman, Wittman, & Smith, 1993). With the passage of the Stewart B. McKinney Homeless Assistance Act in 1987, funds were authorized for a

new demonstration program for homeless persons with alcohol and other drug-related problems (Orwin, Goldman, Sonnefeld, Smith, Ridgley, Mogren, O'Neill, Lucchese, Sherman, O'Connell, 1993). The research demonstration program was developed in conjunction with the National Institute on Drug Abuse (NIDA).

The focus of this ground-breaking initiative was on the implementation and evaluation of community-based alcohol and drug treatment programs specifically designed to assist homeless persons. In May, 1988, the program awarded nine community-based projects to implement and evaluate a variety of services to homeless persons with alcohol or drug problems. Two of these projects were targeted specifically to homeless women with children (New York & Philadelphia) (Orwin et al., 1993).

In 1990, NIAAA/NIDA made a second round of three year awards to 14 projects (Stahler, 1995). While many of the projects were open to women, participants were predominantly male, with notable exceptions. The St. Louis project was specifically designed for homeless women with children. Two projects allowed women but not children (e.g., Tucson and Albuquerque). Only two projects (Los Angeles and New Orleans) included family interventions in the treatment planning (Conrad, Hultman & Lyons, 1993). The dual diagnosis project in Washington D.C. had 65% women, an over-representation of women due to the providers long standing commitment to serving severely mentally ill women (Drake, Bebout, Quimby, Teague, Harris, Roach, 1993). Nevertheless, with the exception of St. Louis and Washington D.C., 75-100% of the sample were homeless men (Stahler, 1995).

Thus, there are three studies funded by this initiative that have specifically focused on addicted homeless women with children (Philadelphia, New York and St. Louis). I will

briefly describe the projects and their contributions to the literature.

The "Family Treatment for Homeless Alcohol and Drug Addicted Women and their Preschool Children" project in Philadelphia, Pennsylvania provided residential care and intensive case management for pregnant and parenting women with preschool age children (Shane et al., 1993). The original design included random assignment to one of two conditions: the residential setting with their children and extensive outpatient treatment (treatment group), and outpatient treatment only (control group). However, the control group was never formed, due to high no-show rates (Orwin, Goldman, Sonnefeld, Ridgley, Smith, Mogren, O'Neill, Sherman, 1994). Key project staff suggested that the program had a high rate of client turnover due to inappropriate referrals of women with multiple needs beyond the scope of the project's capacity (Shane et al., 1993). Unfortunately, due to problems with their original design this project was not included in the national evaluation: consequentially quantitative data is unavailable (Orwin et al.,1994). However, in the project case study did report that these women had limited parenting skills, and needed a great deal of assistance in caring for themselves and their children. The project also extended the 6-month limit stay in the program to some women in an effort to allow more time for them to access suitable housing (Shane et al., 1993).

The "Outreach and Engagement For Homeless Alcoholic Women" in New York City provided outreach services for families residing in welfare hotels. These services were terminated when the hotels were closed down by the City of New York. The project transferred outreach staff to a new site, an apartment-style transitional housing facility for 100 homeless families, a Tier II shelter (Shane et al., 1993). The project sought to engage

homeless women in addiction treatment, by providing supplemental services; acupuncture, education, childcare, housing assistance, employment counseling and placement, and a family life advocate. The Outreach workers, in the often chaotic and stressful hotel environment, at times failed to link alcohol and drug treatment when confronted by women with multiple problems. Instead they addressed the most immediate need and offered a referral to concrete services or offered the supplemental services of the project. Often such practice(s) resulted in a diminished recognition and/or response to substance abuse problems. By making substantial changes in staffing and programming, the Outreach workers were able to identify and link alcohol and drug problems with other problems and engage women in treatment (Shane et al. 1993). Throughout the project, the supplemental services were used to attract and engage women to seek treatment on a voluntary basis (Shane et al., 1993). The findings included a strong and significant relationship between use of supplemental services (acupuncture, education, & family life support) and the number of treatment visits (Ridlen, 1997). Those women who utilized acupuncture, education, and family life support averaged 148.9 visits, while those who relied only on traditional clinic services, attended an average of 7.6 times. The strength of this correlation suggests that comprehensive care engages and maintains homeless women in treatment (Ridlen, 1997).

The "Substance Abuse Recovery Program for Homeless Mothers with Children" project in St. Louis, broke new ground and presented an 18-month follow-up data on 149 homeless mothers with young children enlisted in a substance abuse treatment program. The effects of residential compared to nonresidential services were evaluated. The most salient findings were the low participation and retention rates: a 15% no -show rate and, among

participants who actually started the program, an 85% dropout rate (Smith, North, Fox, 1995). The dropout rate was 1.8 times greater for participants assigned to the nonresidential treatment group. Although not statistically significant, the rate of dropout increased for women with a secondary diagnosis of antisocial personality disorder, and for women with longer lifetime histories of drinking to the point of intoxication (Smith et al., 1995).

The women who were assigned to residential treatment had a lower rate of dropout. About 25% of the residential group left the program in the first month, compared to 50% of the non-residential group. At the third month, more than 75% of the nonresidential group left, compared to 50 % of the residential group (Smith et al., 1995).

The nonresidential treatment experienced problems retaining women in groups. Precarious housing arrangements, on-going family obligations, manipulations and crises of the extended family, transportation, and continued exposure to drugs made it difficult to the members to maintain their involvement in the program (Smith, North, & Heaton, 1993).

CSAT Studies

In 1990, Congressional legislation established the Center for Substance Abuse Treatment (CSAT). It provided an overall mandate to expand the availability of effective treatment and recovery services for those with alcohol and drug problems. This legislation specifically called for expanding treatment and recovery services for women. In 1992, the Division of Clinical Programs (the Division) Women and Children's Branch of CSAT expanded services through two grant programs (the Residential Women and Children 's

Treatment Program and the Residential Pregnant and Postpartum Women's Program). Unlike NIAAA, no project was allowed to budget more than 15% of the federal award for evaluation, and no funds were allowed to be used for control groups as a part of the evaluation designs. Thus, program evaluation was not a high priority in the grant programs marked for women. The agencies funded by these grant programs were for five years. Many of the programs were initiated in 1993, thus reports on the programs will not become available until 1999. In addition, only one program--the N.Y.-- program described in this study--was funded specifically to treat homeless women with children.

Addiction Treatment Approaches

Addiction treatment has been influenced by many theoretical orientations cutting across a wide array of disciplines. These disciplines have included; psychology, social work, family therapy, law, philosophy, and medical science. In 1980, NIDA presented over 40 theories which purported to explain, wholly or in part, the problem of drug abuse (Snyder, 1980). The complexity of addiction problems derives in part from the impact it has on the individual user psychologically, socially, and biologically, and its effects on culture, law, economics, and politics (Lettieri, 1980).

Addiction treatment can be described in terms of treatment approach- a treatment intervention based on a scientific philosophical approach (Landry, 1997). The four primary approaches are 1) methadone maintenance, 2) therapeutic community treatment (T.C.), 3) traditional chemical dependency treatment and 4) outpatient drug free/non- methadone. In

general, these approaches view addiction as a chronic, primary, relapsing disorder. They approaches do not necessarily give consideration to any sub-group of addicts. However, I think a brief overview of the theoretical perspective of these approaches is important to understand, since these modalities inform virtually all addiction treatment in this country.

The methadone maintenance treatment modality entails the substitution of heroin with methadone. The theoretical underpinning of this approach views addiction as a narcotic craving that causes repeated use. Through the use of a synthetic and legal drug like methadone, this craving is alleviated, giving the addict hope for the possibility of rehabilitation and legitimacy (Lowinson, 1981). Despite its success, this approach has been the most controversial and most studied. It conflicts with the puritanical ideology that views abstinence, not maintenance, as treatment success (Lindesmith, 1981). Most recently, the Mayor of New York City proposed to close all methadone clinics. However, state officials and drug experts persuaded the Mayor not to eliminate methadone programs since they were the best hope for the vast majority of recovering heroin addicts (Swarns, 1999).

The T. C. perspective views drug abuse as a disorder of the whole person, and individuals are distinguished along the dimensions of psychological dysfunction and social deficits. Recovery is viewed as a developmental process that requires the integration of explicit social and psychological goals (DeLeon, 1994).

The traditional chemical dependency treatment views addiction as a disease. The treatment approach incorporates the philosophy of the Twelve-Step programs such as Alcoholics Anonymous and Narcotic Anonymous. The disease theory views addiction as a biologically based phenomenon in which a genetic predisposition is activated by psycho-

social and environmental factors (Williams, 1988). Recovery is viewed as a physical, mental and spiritual process whereby the total abstinence of alcohol and drugs is required.

The outpatient drug-free nonmethadone treatment lacks a single core philosophy or theory, with the exception of the focus on treatment as a bridge from active use to abstinence (Landry, 1997).

These four approaches to treatment do not often incorporate the needs of women in treatment programs. All too often a woman will be fit into the "treatment approach" with little consideration for her needs. I will now describe some theories and approaches that enhance the understanding of addicted homeless women with children.

Addiction Theories That Address The Specific Circumstances of Women

Women with addiction have distinguishing characteristics which suggest they need different approaches in evaluation and treatment (Tamerin, 1985). Women with children require a treatment philosophy that focuses on their special needs in the context of a racist and sexist society (Nelson-Zlupko et al., 1995).

New approaches to treatment have been developed to respond to the failure rates of women in traditional addiction treatment programs. These programs are based, in part, on feminist theory, which recognizes the historical and current oppression of women in society in which some women are economically disadvantaged, financially dependent and lack marketable job skills (Nichols, 1985; Reed, 1985; Stevens et al., 1989; Volpe & Hamilton, 1983; Zankowski, 1987). In addition, this approach has acknowledged women's universal

experiences of physical, verbal, psychological, and sexual mistreatment (Miller, 1991; Mondanaro et al., 1982).

Homeless women with children have not generally been treated by the addiction treatment system as requiring a special or different approach, but rather as any woman entering the treatment system. Unfortunately, this means that many of their immediate needs, such as concrete services; food, shelter, personal safety, and housing status are unresolved. This contributes to problems of engaging and maintaining them in treatment.

Perhaps the most innovative psychological theory to explain women and addiction from a feminist point of view is the relational model generated by the Stone Center for Developmental Services and Studies at Wellesley College (Jordan, Kaplan, Miller, Stiver, Surrey, 1991). This model suggests that individuals are most vulnerable to developing an addiction when a problem or gaps exists in one or more areas of interpersonal relationships. The problem or gap may take many forms, for example, negative past experiences that lead to mistrust in current relationships, a lack of a fulfilling interpersonal relationship, loss of significant others, or an environment in which relationships with drugs are safer than investing in people (Straussner & Zelvin, 1997).

This theory is built upon the work of Gilligan (1982), Chodorow (1978) and Miller (1987). Gilligan (1982) differentiated and identified the male moral focus as reflective of separation-individuation and justice, while the female focus was reflective of attachment, caring, and a balancing of conflicting responsibilities. Chodorow (1978) challenges psychodynamic notions that the goal of a healthy human development is separation and individuation, and puts forth the goal of healthy and mutual interdependence. Furthermore,

girls remain connected to their mother to establish identity, and boys are parented to become autonomous to establish their identity (Chodorow, 1978). Thus, for men, failures in independence destroy self-esteem and for women, failures of relationship destroy self-esteem. This theory articulates how girls come to blame themselves while boys externalize their failures. The danger men experience is in connection, while for women danger lies in separation (Gilligan, Ward, & Taylor, 1988). Central to this theory is the notion that psychological development occurs when there is mutuality and empathy in relationships, and through this connection women are able to grow and change.

The treatment implications for women are many, according to this theory. For example, addiction is reframed in relational terms to prevent judgement (I am bad) and disease (I am sick). Instead, an understanding of the problem emerges which reflects it as a misplaced effort to connect in a relationship (Straussner et al., 1997). Basically, this theory focuses on women's strengths and how, in the process of addiction, her strengths become her weakness. That is, she finds a connection in her use of alcohol and drugs and eventually becomes disconnected and isolated due to the lack of "mutuality" between her and the drug. Failures in past and present attempts to become connected with others leads addicted women to have a shame-filled negative relationship with themselves (Straussner et al., 1997). Eventually poor interpersonal skills are developed through failed attempts at connections. Therefore, addressing issues of self-esteem and interpersonal skills is critical in the treatment of addicted women. This theory explains how incest, family violence, negligence, and a range of dysfunctional family dynamics reinforce faulty attempts at growth promoting relationships and mutual empathy.

Relationships with significant others can make or break their efforts at recovery (Laudet, Magura, & Kumar, 1996). For many homeless women, a significant relationship is not limited to family and paramours but extends to those with service providers, friends or family members. Many have developed supportive relationships while others have not. Relationships offer insight into what the predictors of engaging and maintaining these women in treatment might be and these predictors may also have an association to outcomes among this group of homeless women with children. For example, to whom women turn to for help may vary between treatment entry and post-treatment.

The "eco-system" approach in social work also informs an understanding of homeless women and addiction (Germain and Gitterman, 1980). This approach was a response to two historic emphases in social work: one focusing on the individual and his/her internal processes, and the other focusing on the need for environmental reform. The eco-system approach is based on the ecological principles in science, representing a philosophical conception that human beings are in constant exchange with their environments, each acting and reacting on and to the other through continuous adaptations (Germain & Gitterman, 1986). The eco-system approach provides a framework for understanding and helping people with these complex transactions. Intervention is directed toward changing relationships so that people's potential for growth, health, and adaptive social functioning are made more responsive to their needs, rights, goals, and capacities (Germain & Gitterman, 1986). This model underscores life transition, environmental obstacles, and interpersonal processes (Germain, 1981).

This approach provides a useful framework for examining the relationships between

bio-psychosocial factors and post-treatment outcome play in the treatment of homeless and poor women with addiction problems. This approach affords a focus on the individual and environmental interaction. Because of life transitions, environmental needs, and poor communication and relationships, problems may develop in this interaction. The eco-system approach attempts to improve the transactions between people and environments in order to enhance adaptive capacities and improve environments for those who function within them (Germain, 1979). This focus is congruent with working with homeless women with addictions, because here, the work attempts to enhance the clients' coping skills, while taking into account the environmental concerns. For example, many recovering substance-abusing women live in drug-infested neighborhoods where crack and heroin are as accessible as a quart of milk. Therefore, the environment plays a key role in the treatment process and outcomes. This theory provides a framework for understanding formerly homeless women remain sober in these environments after treatment.

Germain and Gitterman (1980) define the social purpose of "matching peoples's adaptive capacities with environmental properties to produce transactions that will maximize growth and development and improve environments." Social workers working in a substance abuse treatment program are severely limited in their ability to change the environmental conditions for their clients. In my experience, it is rare that a social service agency has responded to the housing needs of women. The ability of a social worker to make significant in-roads into the client's environmental circumstances is severely limited by the lack of affordable and safe housing. In this study I will discuss with the client's ability to cope with the environmental pressures and the impact on treatment outcome. For example,

provisions of affordable housing is a positive outcome which has been secured for every client who completes the Casa Rita program. This important provision may improve client's adaptive capacities to maintain the benefits of addiction treatment however, little is known about this relationship.

The systems approach has several tenets that are particularly germane in treating homeless addictive women with children. Primarily, relationships are not viewed as causal, i.e., A plus B causes C. (Bateson, 1972). There is a need to view interactions "holistically," and to understand the complexities of various systems and sub-systems and their interconnectedness with the person presenting a problem. For example, a homeless woman describing alcohol and drug abuse may rank such behavior low on her list of problems. Therefore, it is important to understand the complexities of the various systems impacting her life. Any one particular theory may not adequately capture the complexities involved in her life. For instance, the outcome of her addiction can be explained as an adaptive response to social conditions, poverty, racism, growing up in a dysfunctional family, genetics, depression, abuse, narcissism, etc. According to eco-system theory, none of these reasons in and of themselves would be the cause or cure of her substance abuse. However, they would each contribute to the multidimensional view of systemic causality, which accounts for more complexity in viewing what will help homeless women in the treatment process and the treatment outcome. The systems view emphasizes that forces do not simply move in one direction, each caused by the previous event, but rather become part of a causal chain, each event influenced by the other (Von Bertanalffy, 1981). This tenet is congruent with holistic treatment, which may promote meaningful treatment and contribute to better outcomes in the

treatment process.

In the eco-system model, a framework is provided to include other explanatory theories impacting on the problems, rather than limiting problem categories to interactions and environmental processes (Payne, 1991). This perspective would be inclusive of psychological theory such as the relational model to explain clients' success in the treatment process. Given the complexities of systems impacting the lives of homeless women with addiction, the flexibility in eco-systems allows for a very broad-based analysis of the issues impacting on the client. It is anticipated that such an approach will generate greater understanding of how addicted homeless women with children view their success with addiction treatment.

Trauma

Another important variable to be discussed is trauma. Many studies have found that an estimated 30% to 75% of women with substance abuse disorders have histories of childhood sexual abuse and rape (Root, 1989; Covington, 1982; Wooley & Cook, 1986). Among the population of homeless women who are additionally substance abusers, the estimate is closer to 69% (North & Smith, 1994). The eco-system model is ideal in accentuating the multi-determined etiology that has a strong psychosocial determinant in understanding substance abuse. This allows for new ways to view the interrelationships of symptoms. For example, post-traumatic stress disorder is often masked by substance abuse (Burgess, 1985). The treatment process is enhanced by an appreciation of the exacerbation

of dysphoric affect, which would be anticipated when alcohol and drugs are no longer used to self-medicate. In an eco-system approach, consideration would be given to the other systems that are operating in a woman's attempt to achieve equilibrium. It is important to understand the hard reality which many women face when substances are removed. Thus, an in-depth understanding of the systems in which she is participating may lead to more successes during and after treatment.

Conclusion

The findings of the literature lead to several conclusions concerning homeless women with substance-abuse problems and the role played by individual and structural forces in their lives. Evaluative and epidemiologic research is still lacking on poor and homeless substance-abusing women. For example, assessments of the effects of poverty, multiple traumatic experiences, and factors influencing recovery and success in a homeless addicted population are virtually missing from the literature.

For many women in poverty, program responses based on an understanding of their situations, or on informed social science theory are absent. Overcoming the many barriers to successful intervention with homeless addicted women requires long-term system level reform that provides genuine options in the conduct of their lives.

Throughout this literature review, I have discussed components of several studies and theories that help elucidate the issues surrounding treating the population of homeless addicted women with children. Ecological and relational theory prove useful in their focus

on women and their environment. In addition, both theories provide a holistic approach which allows for a variety of interventions to be employed in identifying desired outcomes. These theories are applied to the reality of the treatment process and outcome, and factors such as life context, poverty, trauma, and mental health among others, are considered. Throughout all the discussion, I continue to find that these studies and theories, while not completely comprehensive, provide the best "fit" for the consideration of the factors relating to the treatment and treatment outcomes of homeless addicted women.

CHAPTER 2

METHODOLOGY

Study Goals

One of the challenges for the field of addiction treatment is to develop a comprehensive framework for providing effective services to homeless women with children. As described in the literature review, engaging and retaining this group in treatment have been difficult at best, and the issue has largely been a neglected area of study. The main tasks of this study were to identify factors associated with success for a group of homeless women and their children who have completed a residential treatment program. The purpose of this study was twofold: 1) to present factors associated with successful treatment outcomes, and 2) to present the factors that both support and challenge respondents' post-treatment lives.

Research Design

This study describes those factors related to the successful treatment outcome for homeless women with children and to their continued sobriety post-treatment. The methodology chosen for this study involves the use of both qualitative and quantitative forms of research to identify variables associated with program completion, and to explain the factors related to program completion and successful post-treatment maintenance. Quantitative methods are especially useful for documenting outcome variables and program

goals and identifying specific variables which are related to program completion (Smith, 1990). Qualitative methods allow for greater attention to matters of the process and complexities, due to the flexibility of the methodology and potential richness of qualitative data (Patton, 1991). The qualitative methodology allows for further exploration and description of the personal elements, relationships, and other factors to which these women attribute their success from addiction.

This study utilizes the process of "method triangulation," the integration of qualitative and quantitative methods in which qualitative data are compared with quantitative findings to determine if both methods lead to similar conclusions (Smith & Fabricant, 1992). It is not uncommon that findings from qualitative data are contradicted by quantitative data, and vice-versa (Patton, 1991). Nevertheless, the validity of findings is greatly enhanced when quantitative findings are supported by qualitative findings (Patton, 1991).

The experimental design in quantitative methodology is the most rigorous method to best establish cause and effect relationships. Quantitative methodology allows for a comparison between different forms of treatment intervention, and/or no treatment, to determine the various effects of each (Black, 1993).

Despite the rigor of experimental designs this method has been controversial in the evaluation of drug treatment and other social service programs. The ethical and moral dilemmas of experimental designs involve the use a control group and random assignments of clients to treatment protocols. In effect, the methodology, in its most rigorous form, requires practitioners to withhold treatment to establish this control group. The denial of treatment to those seeking it raises ethical concerns. It is understandable that many social

workers and counselors have difficulty carrying out these protocols for homeless women and children as well as others in need of services. In such cases the use of a waiting list, or a contrast group is more humane (Smith, 1990). Unfortunately, Case Rita did not have a waiting list or a contrast group to serve as a control group.

Random assignment often means placing the individual seeking treatment in treatment modalities or interventions that may not be in his or her best interest (DeLeon, Inciardi, & Martin, 1995). Interestingly, by employing random design, the client samples may create a program which is so different from one composed of individuals selected through traditional recruitment strategies that the program itself may actually change. In such a case, the evaluation may be examining an artificial treatment initiative (DeLeon et al., 1995). Typically, social workers and counselors provide assessments and evaluations of the client's need for treatment and the appropriateness of a particular modality. The social worker's code of ethics clearly articulates that the "Primacy of Client's Interests" is the social worker's primary responsibility (NASW, 1993). This tenet clearly describes that a social worker's primary responsibility is to determine which treatment would be better for a given client, based on a diagnosis. Arguably, random assignments would be in direct contradiction of this principle. In those ways, random assignment creates conflict between researchers and human service workers (Smith, 1990). For those reasons, the design of this study did not include a control group or the use of random assignments.

There are other challenges which complicate the evaluation of treatment programs and the isolation of significant factors leading to success. One such challenge is that treatment is a "black box," i.e., a process which is largely undescribable, due to the interplay

of numerous other factors which may influence the treatment experience. These factors may include; individual motivation, maturation, relationships, family, friends, environment, and luck (Ball & Ross, 1991). For example, in alcohol and drug treatment, the effects of participation in self-help groups are particularly difficult to control. Research protocols cannot exclude or include clients based on participation in self-help groups. Participation in self-help groups undoubtedly affects treatment outcomes, yet these effects are not often controlled for. This is only one example of why and how the evaluation of drug treatment programs and finding out what works in treatment and post-treatment are challenging tasks for the researcher. We can begin to appreciate why studies which not only examine variables predicting program completion but also inquire into the subjective experiences of clients' are extremely useful in discovering what works (Westermeyer, 1989).

Addiction treatment programs require ongoing evaluation, especially to determine the value and efficacy of the program model for the particular population composed of women and children (CSAT, 1994). The best evaluations often identify the factors which contribute to client change. With this in mind, it is crucial to simply ask the clients' own view of the relevant influences affecting her success (DeLeon et al., 1995).

In keeping with the qualitative methodology, the general questions that frame this inquiry are:

* In what ways does being homeless influence clients' decision to obtain treatment?

* What are the important aspects of treatment?

* How do family/child and other relationships influence the recovery process?

*What does it take to sustain sobriety post-treatment?

* What are the obstacles to remaining drug- and- alcohol free, and to what extent are these factors individual, relational and/or environmental?

* What relationships are sources of support?

* What are the relevant variables and categories of experience that can account for maintaining sobriety post-treatment?

* What are clients' understanding of themselves and their recovery process?

This study incorporates multidimensional approaches to develop a holistic understanding of the factors which motivate a woman to enter residential treatment, complete treatment and remain alcohol and drug free post-treatment. The incorporation of several approaches recognizes the need for a researcher to be open to looking at phenomena from different points of view (Patton, 1990). The following will describe the quantitative, theoretical, and qualitative approaches utilized in this study.

Quantitative Approach

This methodological inquiry conducted relies on existing quantitative data from Casa Rita's data base. The quantitative focus of this study was to compare data from intake to determine which factors, if any, were associated with treatment completion. The quantitative methodology includes descriptive statistical procedures that provide general information about the study sample. Demographics of a group under study can provide important information to understand the population regardless of whether further inferences can be made (Black, 1993).

The quantitative design is informed by this program's findings of predictors to program completion. The four variables, length of homelessness, past treatment experience, having a father with a substance-abuse problem and having a partner with a substance-abuse problem, either were statistically significant or had a strong relationship to program completion. Building upon this quantitative data, as described above, the qualitative study further explores and describes personal factors, relational, and other factors to which these women attribute post-treatment recovery from addiction.

Program completion was viewed as client success. The three key requirements needed to complete the program included; 1) remaining alcohol and drug free for a continuos period of six months, 2) achieving the goals of the individualized treatment plans, and 3) reunifying the family or resolving foster care issues. For every client who completed the program, the length of the stay was a minimum of one year.

The participants of this program were selected for investigation due to the specific nature of the program which lends itself to the case study approach. The program was chosen for several reasons:

1) The treatment design of the program was specifically chosen to address addicted, homeless women with children. The treatment approach intentionally did not separate women from their children during treatment. The program had a history of struggling with the questions of this study, i.e., what factors contribute to the successful treatment of homeless addicted women with children.

2) The program had a well-developed philosophy of treatment. This included viewing addiction as a disease and an attempted coping mechanism for other life problems.

3) The researcher had accessibility to the program. The fact that the researcher participated in the design and administration of the program as the administrator of the program provided a unique perspective. As discussed later in this chapter, this role has the potential to yield significant insights as well as tensions.

Casa Rita's Approach to Treatment

The following is a description of Casa Rita' s approach to treatment:

The Casa Rita treatment program incorporates a unique approach to addiction treatment services. Based on an overarching belief in the innate dignity of program participants, policies and interventions are geared toward the unique individual needs of each client. Addiction is viewed as a disease, and prior life circumstances and addictive behaviors are respected as integral parts of participants' histories, to be honored and used as bases for growth and change. Clients are not pathologized, but rather are seen as individuals seeking to improve their lives. This philosophy of respect is evidenced in program policies and treatment components.

One critical component of treatment at Casa Rita is the provision of individual and group counseling as well as family therapy. Another major philosophical and treatment component involves the intentional approach towards clients' child/ren. A major component of Casa Rita's approach includes the recognition of the importance of the presence of the client's child or children in treatment. This view is supported by both corresponding attitudes and allocation of resources, for example, provision of childcare services and

allowance for release time from treatment to attend to family matters, such as Family Court. Staff attitudes are another critical aspect of the Casa Rita treatment success. Respect for clients is reflected in non-pathologizing approaches towards addiction and prior life events. In addition, respectful and knowledgeable staff contribute hugely to clients' successes. Other program policies, based on respect for clients, are also critical to the success stories at Casa Rita, such as providing individual and private rooms, and allowing freedom of mobility. The following will briefly describe some aspects of these ingredients as they are provided at Casa Rita.

The unique attitude towards children is, perhaps, the major critical treatment component which contributes to the success of Casa Rita clients. Child-care is provided for all children, and consists of trained personnel on-site six days a week. The hours of child-care are from 9:00 A.M. to 3:00 P.M. The child-care rooms are in the same building as the treatment program which provides easy access for the parents. There are three distinct sub-groups by age: infants (up to 12 months), toddlers (15-33 months) and preschoolers (34 months to 5 years). The infants are generally in the child-care setting during the mothers' treatment activities (4 hours per day). The toddlers and pre-school children generally spend 6 hours in day-care. Parents in the program do not have required responsibilities or functions in the day-care program. However, parents are required to initially spend time with their children in the day-care setting to assist with their child's adjustment there.

When not in day-care, children in the program are primarily supervised by their mother. Parents are responsible for their children when they are not in day-care or are sick. In situations when children are sick, parents are excused from treatment activities to care for

the child. On some occasions, other peers in the program baby-sit while the mother attends group or individual counseling. In many residential treatment programs, children are supervised 24 hours a day by trained personnel and are re-united with their parents only as women progress in the program. The Casa Rita program was designed to treat women and children together, viewing both the child and mother as integral to the recovery process, but as unique people with differing needs. As such, conflict might arise between the needs of the child and those of the mother. For example, a mother might drop off a sick child, so that she could attend her program activities, such as a group. In such a circumstance, counseling staff would value the need of the mother to participate in treatment, while child-care staff would value the need of the child to remain in their room and rest. Furthermore, the child might be a source of infection to the other children. Where resources are limited and a difficult choice must be made, these tensions are inevitable.

Counseling and therapy are parts of virtually all treatment modalities, but Casa Rita's approach to counseling recognizes the unique needs of each client, as well as the specific needs of the homeless, addicted mother with children. Each participant is initially assigned a counselor. Individual therapy sessions are indicated once a week and but provision is actually based on a client's need, which she herself determines. As described, provision of therapy often exceeded the traditional 45-minute or hour session time, and occurred at virtually any hour, as needed. Clients reported the importance of flexibility to their sense of trust as well as to their ability to attain sobriety. In addition to individual sessions, clients participate in several group therapy meetings. Groups are named to reflect the content issues, i.e., Addiction Education, Relapse Prevention, Parenting, Healing, Relationships, Women's

Issues. It is evident through the group names that emphasis is placed on gender issues as well as on the roles of clients as mothers, another example of the appreciation of the program for the role of the client in her relational world. Some groups are based on the needs of specific women. For example, the group "Healing" consists of women who have been sexually abused. Typically, to avoid overwhelming clients, members have at least three months in the program prior to joining this group. Other counseling, such as "Family Therapy" often begins immediately upon entry into the program, contingent upon availability of family members. "Family" is considered anyone the client so identifies, again an example of according the client the respect to decide for herself who important "family" members may be.

The attitudes of staff are critical to any treatment modality, and reflect the overarching philosophy of the program. In many treatment modalities, clients are treated as "losers" who must prove some sort of achievement before "privileges" are allowed. By contrast, the attitudes of the Casa Rita staff are based on respect and appreciation of the client's growth process. Non-judgmental attitudes which avoid confrontation lead to clients' feelings of safety and an accompanying ability to open up, confide, share, process, bond and heal.

Respect for clients also leads to program policies which afford them rights usually denied in traditional or typical treatment modalities. It is recognized, for instance, that clients, although in residence at an in-patient treatment facility, nevertheless have other life obligations. Clients are therefore allowed to leave the facility to attend to other matters which may arise. Traditional treatment modalities typically view such measures as too risky

and too liberal. In addition, each client family has a space of its own, in a private room, which can be locked from the inside. Such housing accommodations are often not available in traditional treatment modalities, or are provided only as a "reward" for good behavior or accomplishment.

The quantitative data provides data on all participants of the program whether they completed treatment or not during the years under study. The case study approach enables the researcher to view the entire universe of participants in this program. The limitations of this design include the inability to generalize to a larger population. The advantages of this approach are the ability to identify and suggest possible relationships among factors and provide support for further study (Black, 1993). For these reasons, this approach fits this study's goals: to identify factors associated with success for this population.

Theoretical Approach

The study incorporates two theories, the eco-system theory and the relationship model. The eco-system approach provides a useful framework for examining the role of individual and environmental interactions which contribute to the recovery process. This social work approach, adapted from systems theory, also includes other explanatory sub-theories impacting on problems, rather than limiting problem categories to interactions and environmental processes (Payne, 1991). Given the complexities of systems impacting the lives of homeless women with addiction, the flexibility in eco-systems allows for a very broad-based analysis of the issues impacting on the lives of recovering homeless women with

addiction.

Relationship models (Miller, 1976; Jordan, Kaplan, Miller, Stiver, & Surrey, 1991) focus on the strengths women bring to relationships. In this model, relationships provide a source of self-esteem, a factor posited to reduce the need to rely on substances. Relational theory supports the hypothesis that addiction represents, at least in part, a misplaced striving for connection. The approach suggests that individuals are most vulnerable to developing an addiction when a problem or gap exists in one or more areas of interpersonal relationships. The gap is then filled by entering into a relationship with the drug. Therefore, recovery takes place in the context of building and strengthening relationships with self, loved ones, and society (Byington, 1997).

Recovering addicts have to come to terms with their relationships with others. It is often her relationship with children, partners, and friends which are sources of guilt and shame, and contribute to a woman's cycle of addiction. Children, parents and friends often have difficulty forgiving her, and these relationships have to be rebuilt and strengthened (Cusack, 1984). For recovering women, like for all people, relationships provide the emotional support to cope.

This study utilizes a qualitative approach to gain an in-depth understanding of a sample of women who successfully completed treatment at Casa Rita. Although this study does not fit neatly into anyone theoretical perspective, as a qualitative study, it does reflect a phenomological perspective (Bogdan and Biklen, 1983). I have conducted descriptive analysis which integrates several theoretical approaches. The qualitative aspects of this are illustrated by the major focus on the essence of the experience of successful clients. The data

was collected through the use of a semi- structured interview (Patton, 1990). The elements of the open-ended interview, described by Patton (1990) and the findings of the quantitative evaluation study, described above, guided the framing of the interview questions. The open-ended interview consists of asking all respondents the same basic questions and in the same order (Patton, 1990). In this interview guide, questions first asked respondents to speak about their past experiences with past treatment and circumstances that led to their realization that substance abuse was a problem. Following questions specifically asked about important influences in maintaining sobriety (see Appendix for interview guide).

Qualitative Approach

Qualitative analysis is important to gain an understanding of the meanings and ways clients explain their experience in residential treatment. In addition, qualitative analysis serves to delineate the wider sociopolitical and ecological context in which substance abuse and recovery take place. Relational and environmental factors influencing recovery among this population were also explored.

As Denzin and Lincoln (1994) note, the word "qualitative" implies an emphasis on process and an in-depth understanding of perceived meanings, interpretations, and behaviors, in contrast with the quantity, frequency, or intensity of externally defined variables. Qualitative inquiry permits an investigative intimacy with one's research subjects that is unlikely through reliance on quantitative approaches. "The commitment to get close, to be factual, descriptive, and quotive, constitutes a significant commitment to represent the

participants in their own terms... faithfully depicting what goes on in their lives and what life is like for them, in such a way that one's audience is at least partially able to project themselves into the point of view of the people depicted" (Lofland, 1971, cited in Patton, 1990, p.32).

The literature review that was undertaken as part of this study revealed few addiction treatment programs serving homeless women with children, and none that set out to document the factors related to success. For this reason, the case study approach was selected as the specific strategy for exploring the factors related to client success. It is "...useful where one needs to understand some special people, particular problem, or unique situation in great depth, and where one can identify cases rich in information -- rich in the sense that a great deal can be learned from a few exemplars of the phenomenon in question... Regardless of the unit of analysis, a qualitative case study seeks to describe the unit in depth and detail, in context, and holistically" (Patton, 1990,p.54). The case study approach allows the researcher the ability to shed light on the subtle variations and tensions as well as the contradictions and dynamics of the phenomenon.

The desires to evaluate individualized client outcomes of those who successfully completed the Casa Rita program suggest the case study approach. In this study, gathering of in-depth data on specific clients was used to illuminate the factors associated with success. The focus was on the clients' descriptions of which factors were helpful or not helpful in residential treatment; relationships and other factors which influenced recovery; and clients' challenges. The uncovering of the complexities of these women's lives pre-and post-treatment is the main strength of this research methodology. In addition, findings can also

contribute to both program planning and theory development (Starke, 1986). As Mintzberg has written, "(W)e uncover all kinds of relationships in our hard data, but it is only through the use of this soft data that we are able to explain them, and explanation is of course the purpose of research" (1983, p.113). The methodology of this study reflects the strategies which best serve the case study approach. The following will describe the quantitative sampling criteria and quantitative analysis conducted in this study.

Quantitative Sample

The sample was taken from Casa Rita, a residential program operated by Women In Need, Inc., a not-for-profit agency. The residential program has a maximum capacity of 16 homeless women with addiction problems, and 40 children. The sample strategy used in this study was criterion sampling. According to this method, all cases that meet predetermined criteria of importance are included in the study (Pattton, p.176). To be eligible for treatment in the Casa Rita program, a potential client had to meet multiple criteria imposed by multiple agencies. For example, the program itself was designed for women with children. The Office of Alcoholism and Substance Abuse Services, funders of Casa Rita, required a diagnosis of a substance abuse problem. The New York City Department of Homeless Services, also funders, required that all participants be assessed as homeless families (pregnant or with children) by their own personnel at the Emergency Assistance Unit. In addition, requirements of a grant from the Center of Substance Abuse Treatment mandated –amongst other things--the systematic documentation collection at both intake and program

completion. Data was also collected by counselors in the regular course of treatment provision and assessment. These multiple criteria which in fact defined the population of clients treated at Casa Rita were also used to determine eligibility for the study. In final form, criteria included the following: sample members must (1) be a woman; (2) be homeless as defined by NYC Department of Homeless Services; (3) have a diagnosis of an alcohol and/or substance abuse problem; and (4) be pregnant or have a child or children in her custody.

Data collection began in March, 1993 and ended in July, 1997. The sample for this study consists of 65 clients who participated in the residential treatment program during that time. Of the 65 clients, 42 (64%) completed treatment and 23 (36%) did not complete treatment. In this instance, and of import here, the sample includes the universe of this population.

The data for the quantitative descriptions was taken from the existing data base of the residential treatment program pertaining to the clients in the study sample. The data was taken from the baseline interview administered upon the woman's entry into the program, and includes the Addiction Severity Index (ASI). This index is a standardized assessment measuring the lifetime and recent (past 30 days) severity of problems in seven areas commonly affected among alcohol and drug-dependent individuals. The areas include medical status, employment and self-support, alcohol use, drug use, legal status, family and social relationships and psychiatric symptoms. The ASI has been widely used since 1980 and has been repeatedly found to offer reliable and valid measures of patient status in these seven areas (McLellan et al., 1992).

The quantitative data base of 65 clients provides a detailed descriptive profile of the subjects. This profile includes the following variables; socio-demographics characteristics, length of homelessness, lengths of alcohol and other drug use, relationship status, number of close friends, medical history, physical abuse, sexual abuse and program completion. For the analysis of the relationship between program completion and prior substance abuse treatment, and program completion and family members with a history of substance abuse, the data base consists of 51 and 63 clients, respectively. This decrease in sample subjects is due to missing data in the primary data source. The researcher must be aware of the limitations of utilizing archival data sets, given the possible errors in record keeping and changes in the manner in which records are made (Shaugnessy & Zechmeister, 1985). Fortunately, the researcher's involvement in the program as the Co-Principle Investigator provided access to and awareness of the limitations of the data base.

Data collection was financed in part by the federally funded grant the program received during the period of this study. The funding enabled the program to pay for data entry staff, which is often unusual in small drug treatment programs. Data entry was monitored by the Director of Research to minimize data-entry mistakes, enhancing the reliability of the data.

Quantitative Data Analysis

The quantitative analysis was conducted using the SPSS 6.1 for Windows (base system and advanced statistics). The basic research paradigm is a descriptive analysis which

includes: demographic characteristics, personal and family history of alcohol and other drug use, medical and personal history, and psychological status based on baseline data and whether they completed the program or not. The statistical analyses also focused on examination of the association between baseline variables–length of homelessness, prior treatment experiences, having a partner with substance abuse problems, having a mother or father with a history of substance abuse problems-- and an outcome measures of program completion. These analyses used either t-tests or chi-square tests for means and percentages, respectively. This data provides a context to the qualitative study, a broadly defined research study which seeks to describe the factors related to successful outcomes of residential treatment for alcohol and drug dependency on alcohol and drug use in a population of homeless women with children

The following will describe the qualitative sampling criteria, conducting the interview, and the qualitative analysis conducted in this study.

Qualitative Sample

The purpose of qualitative inquiry is to explore an issue deeply, not necessarily widely. Such a study generally focuses on relatively small samples that are selected purposefully, because they contribute information related to the study's goals. A sampling strategy was selected that provided information- rich cases from which we could learn a great deal about the issues central to the purposes of the study (Patton, 1990, p.169).

The sample selection for the post-treatment interview employs the intensity case

sampling strategy. This sample selection consists of 20 clients who completed the program and had, at the time of the interview, remained alcohol and drug free. An intensity sampling strategy was used to capture the experiences of those participants who were selected to be interviewed because they had completed treatment and remained alcohol and drug free post-treatment (Patton, 1990). The intensity sampling includes a focus on information rich cases which are based on the desire to capture the experience of those women who have been successful (Patton, 1990). This number was selected because they comprised the available universe of clients. It was assumed that in-depth interviews with post-treatment clients would provide adequate data for the purposes of this study.

Conducting the Interview

Participants were contacted by phone to discuss the study and to request their participation. Interviews were taped in order to transcribe verbatim records. For purposes of confidentiality respondents were given a choice about the tapes, sixteen tapes were destroyed, once transcribed, and four were sent to the participants after transcription upon their request. Some participants wanted the tape as further confirmation and testament of their recovery process. In seeking each participant's cooperation with the purpose of the study, assurances of confidentiality and anonymity, for both the individuals and agency involved, were provided. The length of interviews ranged from one hour and one half to three hours. Each participant was paid ten dollars for an interview.

The validity and reliability of self-reports become problematic, especially when the

subjects of discussion of are of a sensitive nature, such as substance abuse. It has been suggested that substance abusers are more likely to report accurately, without distortion, and with less regard to social desirability factors when they are told the exact purpose of the data collection, i.e., the identification of factors important to maintaining sobriety, and when they are assured of the confidentiality of their responses (Werch, 1990). Prior to the interview, respondents were told the purpose of the study and the extent of confidentiality. They were told if there were evidence of psychological, physical or medical difficulty of a serious nature, a prompt referral would be made to access appropriate professional help or consultation. Respondents were also told that because the researcher was a certified social worker, there were requirements of child protection laws mandating the report of any incident of child neglect and /or abuse.

A standard open-ended interview guide was utilized to minimize interviewer effects by asking the same question of each respondent (Patton, 1990). This was particularly important in this study where the researcher and respondents had a prior relationship. The use of an interview guide can reduce the effects of subjectivity and bias when the researcher is very familiar with the subjects (Lofland &Lofland, 1995).

The interview guide afforded the dual advantage of making the interview more systematic and comprehensive by identifying the issues to be investigated, yet providing maximum flexibility and leeway so that spontaneous exploring of emerging material could most easily take place. A pilot of the interview guide was carried out with women in recovery who had successfully remained sober after treatment. In addition, the guide was reviewed by experts in the field of addiction. The questions in the guide reflect the theories

informing this project and the reported experiences of previous program participants. The thoughtfulness of the structure, wording and sequence of the questions and prompts in developing the guides were as important as the process of conducting the interview. Both the interview guide and conducting the interviews are important factors in assuring reliability and validity. The interview guide provides a systematic framework and the interview provides the method to understand the dynamics at play that influence the subject under study. Nevertheless, there are limitations of using a standard open-ended interview guide, Patton (1990) describes the lack of flexibility in relating the interview to particular individuals and circumstances. The choice of utilizing a standardized open-ended interview does limit pursuing in greater depth important issues that arise in the interview process.

The political and ethical problems of gaining access and maintaining the commitment of the participants in the study was minimal. The quantitative data had already been collected and entered into the SPSS program. The qualitative aspects of the project had been secured by following procedures that included both verbal and written information about the study, the limits of confidentiality, and possible risks to participants. All respondents signed an informed consent form. The researcher had been the Co-Principle Investigator for five years on the project and had been Acting Program Director for a six-month period during the project. Thus, the researcher was in a unique situation to know the program and many of the clients. WIN had provided a list of names and addresses and telephone numbers of the 40 subjects who had completed the program and participated in a post-treatment interview. Eighteen of these participants were identified by either self-report or by two key informants (counselor and\or other clients) as having relapsed. Twenty-two participants of this group

did not report a relapse in post-treatment interviews nor were they identified by others as having relapsed. The role of key informants in selecting the interviewees can minimize the potential intrusion of the researcher's subjective bias (Lofland &Lofland, 1995, p.65). By telephone, I secured twenty interviews from the twenty-two identified participants The telephone call consisted of informing the woman about the purpose of the study, the consent form, as well as securing a time, and a meeting place to carry out the interviews. Amazingly, after I called and interviewed a few subjects, other targeted respondents whom I had not yet located heard about the study from the interviewees and called me. Thus, there were minimal problems in finding and interviewing 20 of 22 women of my sample. All 22 were located, two were not interviewed since one moved to South Carolina, and another was not able to schedule time due to working twelve hours a day, running a grocery store with her new husband. The final sample for the qualitative inquiry therefore comprised 20 respondents.

Interviews were scheduled at the convenience of the participant. Many scheduled the interview for the next day or, in some cases, the very evening of my phone call. Interviews which were scheduled for more than three days away from the telephone call were occasionally forgotten or had to be rescheduled by the respondent. On occasion, I went to these respondents' homes two to three times before the interview was conducted. My flexibility and availability in meeting with the participants was critical. I met with participants as early as 7:30 A.M. and as late as 10:P.M. due to childcare and employment issues. Interviews were scheduled every day including Saturdays and Sundays.

Nineteen interviews were carried out in participants' homes and one at a WIN shelter

convenient to the participant. Most of the participants knew me from my role as Co-Principle Investigator and Acting Program Director. Therefore, for some, the initial part of the interview was like a reunion, pictures were shared, and common interests discussed. Most remarkable was how proudly they showed me around their fully furnished and neat apartments. Many had certificates of completing the program framed alongside of family photos and other certificates of achievement.

The role of researcher is to establish a rapport with the interviewee that is neutral and does not influence one way or another what the interviewer says (Patton, 1990). Due to the researcher's prior role as a person of authority at the treatment program, it was particularly important that respondents be able to speak in their own voice without being influenced, consciously or unconsciously by the researcher. Under the circumstances of this project, a tension between the objectivity of the role of the researcher and the subjective experiences of respondents' prior relationships with her in the treatment program was inevitable. It is impossible to know to what extent respondents were influenced by the prior relationship with the researcher. With the potential for influence, however slight, in mind, the researcher took several steps to ensure objective self-reports, uncontaminated by prior relationship dynamics. To this end, the researcher purposely took a stance of being respectful and thoughtful, a peer to the respondent and appreciative of her voluntary agreement to participate in the project. The researcher emphasized the importance of confidentiality, the purpose of the inquiry and her role as a student/researcher. Any residue of a former position of authority was consciously eradicated by the researcher's stance in these interviews. In these ways, respondents were supported to speak openly about negative as well as positive aspects of

their experience at Casa Rita and post-treatment.

Some social scientists question whether "outsiders" like the researcher can give an account of another person's experience (Lugones & Spelman, 1986). They maintain that only when genuine and reciprocal dialogue takes place between outsider and insider can outsider accounts be trusted. The outsider must make herself vulnerable and unimportant to gain insiders' trust (Ralston, 1995). The researcher was the Co-Principle Investigator and Acting Program Director, and as such, held positions of importance and authority in relationship to these participants. However, most were aware of the researcher's history with alcohol and drug addiction–a fact which led to a different dynamic within the relationship, one in which I was viewed and treated as an "insider," or "similar other," who could be trusted to speak the truth. During the course of the interview with the participants, it was very important, in my own way and using a simple language, to provide a nonjudgmental, supportive and reciprocal relationship, without establishing a clinical relationship. Participants were eager to share their experiences with me and to solicit my advice.

As a researcher, I was aware that my role in carrying out the interview had no clinical mandate to assist the participant in solving present life difficulties (Padgett, 1998). It was important that respondents be clear about my current role as a researcher, not as a traditional social worker, available to assist them with their problems. At the same time, after the interview was over, I did on occasion offer suggestions and/or referrals if appropriate. For example, two respondents did not have health insurance for their children. The fathers of these children were living with the respondents and both had union jobs with fringe benefits. The respondents were unaware that their children were eligible under the father's health

insurance for benefits, although they did not use their fathers' last name, but had the name on their birth certificate. In other situations, tenant laws and the Section 8 vouchers were misunderstood. In these situations, the researcher offered information and referred respondents to WIN housing specialists for further assistance. Because the clear focus of the appointment was the interview, and any information offered came at the end of the visit, almost as a postscript, there was no confusion in the researcher's mind about her mandate, nor was there any tension or confusion of agendas with any respondent.

Qualitative Data Analysis

The qualitative inquiry began immediately after writing up the interview. Time was spent studying and analyzing the interview and the material. I transcribed the interviews and, at the end of every interview, noted the themes and issues that had been raised. The qualitative analyst's effort at uncovering patterns, themes, and categories is a creative process that requires making carefully considered judgements about what is significant and meaningful in data (Patton, 1990). For purposes of this study, the data was translated and coded into categories and subcategories of analysis which explained the client's experience. Typically, in the process of analysis, particular themes emerged as central to the analysis (Patton, 1990).

During the initial stages of the analysis, the interview guide itself was used as the descriptive analytical framework for analysis. A cross-interview analysis for each question in the interview was reviewed. In doing these analyses, particular themes central to the

clients' experience were located.

Miles and Huberman (1994) describe the process of data analysis through cross-case analysis by moving beyond simply summarizing superficially across some themes or main variables. Rather, these authors advocate looking carefully at the complex configuration of processes within each case and understanding the local dynamics before beginning to infer patterns of variables that transcend particular cases. Therefore, this analysis paid particular attention to these issues of superficiality.

Each interview was read and analyzed separately several times. Sentences and paragraphs were listed and then coded by suggested theme. This was done several times to ensure comprehensiveness. Codes were then merged into categories. Some codes occupied a central place in the analysis while others were collapsed or dropped (Lofland & Lofland, 1995). These selected codes were placed in appropriate categories that eventually were emerged into themes and typologies that best described the categories.

In implementing the suggestions of Miles and Huberman (1994), I also used both an inductive and deductive approach to better operationalize the theories informing this study, and too more thoroughly explore the phenomena of completing treatment and maintaining sobriety. Locating and finding relationships and themes in the data allowed for the accomplishment of these goals. Specifically, the researcher located in each interview the respondent's descriptions of the important aspects of treatment at Casa Rita, past treatment experiences, relationships, obstacles etc. and coded the strips of data. Similar to the above process, categories within the selected codes were elaborated.

The identification of themes that cut across cases is a major strength of the qualitative

analytical approach. The challenge for the novice researcher is to deal with the complexity of the coding process, which involves being familiar with all the data, and creating accurate categories. This involves assigning codes, categorizing naming and developing themes, and remaining flexible with any of these processes as new insights are gleaned (Miles & Huberman, 1984). The importance of using language that most accurately captures categories and themes is important in qualitative analysis. The novice researcher may approach her qualitative study with preconceived categories or themes which may be unsupported by the data. Conversely, she may be timid and loath to take the leap to create a new category or articulate a new theme, even when the data support it. It is important that the researcher utilize her experience and knowledge while clustering data and naming themes in order to be able to move from descriptive codes to interpretive themes (Fabricant, 1996). This approach provided the mechanism to analyze the data so that it could provide a framework for the treatment success of these women.

Reading the interviews and coding the data were characterized by rigorous attention to the detail of the data, and assuring that the concepts and theories came from the data. In order to assure the validity of the interpretation of data, the researcher must be immersed in it, have an open mind, and be informed by knowledge, intuition and sensibilities (Lofland & Lofland, 1995).

The study participants are predominantly women of color, and it is assumed that all of them have experienced racism, sexism, and classism. As a white woman analyst, it is very important for me to be sensitive to the importance of these dynamics. Patricia Hills Collins (1991) argues that qualitative research that places black women's experience at the center of

analysis offers fresh insights on the prevailing concepts, paradigms, epistemologies of the male European world view and on its feminist and Afrocentric critiques. The researcher attempted in the analysis to be sensitive to and reach for a deeper understanding of these phenomena as well. To further ensure validity, an expert on diversity issues reviewed the interpretations for possible misunderstandings of these issues.

CHAPTER 3.

QUANTITATIVE FINDINGS

In this chapter, I will present demographic descriptions and findings of variables associated with program completion. It is important to mention that the population treated at this facility is among the most distressed population of New York City. The population of addicted homeless women with children has experienced numerous hardships which have origins in familial, social economic, and political situations. The numbers reported represent the experiences of those individuals who have made an effort to change their lives by attending the Casa Rita program, whether or not they completed treatment.

Profile of Participants Treated in the Residential Program

A demographic profile of the families at Casa Rita is presented in Table 1 through Table 1.3. The average age of respondents was 30 years old, and they had an average of 2.4 children. These women were the primary providers for their children. The average number of years of school completed was 10.6 (Table 1). The majority (70.8%, n=46) did not complete high school, while 15.4% (n=10) received a High School diploma and 13.8% (n=9) received a General Equivalency Diploma (Table 1.2). These numbers suggest an unusually high drop-out rate from school. For example, in New York State the 1985 drop out rate for teens was 9%. This percentage declined to 8% in 1994 (Casey, 1997). The high drop-out rate suggests that problems for this population started very early, and they were

experiencing a lack of success and trouble prior to being an adult.

Approximately, thirty-five percent (35.3%;n=23) reported that they were in a stable relationship with an additional 9.2% (n=6) reporting that they were married (Table 1.3). Forty-one and a half percent (n=27) reported that they did not have a romantic relationship. A small group reported that they12.3% (n=8) were divorced, and a smaller group 9.2% (n=6) were married. These demographics suggest that family structure did not include marriage, which is often viewed by policy makers as a solution to women's poverty (Abramovitz, 1988). However, for poor women and women of color, marriage to higher income breadwinners is increasingly problematic because of the same issues she confronts; low wages, an unstable labor market and discrimination in the labor force (Bane, 1986). For poor women, the reliance on the government for support may outweigh the economic benefits of marriage (Gordon, 1988).

The majority of respondents were African American (69.2.%, n=45), while 23% (n= 15) were Latina/Hispanic and only 8% (n= 5) were white. Obviously, the racial characteristics of this group are overwhelmingly minority (Table 1.4). Race was is an important variable in predicting family shelter use in New York City (Culhane, 1994), and in that study African-Americans were found to utilize family shelters more than other ethnic and racial groups in New York City. African-American families were at greater risk for homelessness than others with similar risk profiles, i.e., persistent poverty, impoverished social networks and loss of affordable housing. (Shinn, Weitzman, Stojanovic, Knickman, Jimenez, Phil. Duchon, James & Krantz, 1998). Explanations have included housing discrimination and the inability to "double -up" with family and friends, and lack of other

informal support networks.

TABLE 1

RESIDENTIAL FAMILY TREATMENT FOR HOMELESS ADDICTED WOMEN

DEMOGRAPHIC CHARACTERISTICS

N=65

	Mean	Range
Age	30	19- 39
Number of Children	2.4	1- 6
Number of Years School Completed	10.6	7- 14

TABLE 1.2

EDUCATIONAL STATUS

N=65

	Number	Percent
No Formal Diploma	46	70.8%
High School Diploma	10	15.4%
General Equivalency Diploma	9	13.8%
Total	65	100%

TABLE 1.3

MARITAL STATUS

N=65

Marital Status	Number	Percent
Stable Relationship	23	35%
Married	6	9%
Divorced	8	12%
Widowed	1	2%
Not Married/Not in Romantic Relationship	27	42%
Total	65	100%

TABLE 1.4

RACE/ETHNICITY

N= 65

	Number	Percent
African American	45	69%
White	5	8%
Latina-Hispanic	15	23%
Total	65	100%

Personal history of drug and alcohol use of participants is presented in Table 2. Respondents reported an average of 9.5 years of alcohol use, 6.7 years of cocaine/crack use, and 7.4 years of marijuana use. For most participants (61% n=40), poly drug use was

reported for an average of 5 years, with a range from 8 months to twenty-five years. 27.5% (n=11) reported poly-drug use for more then ten years, while, 42% (n=17) abused substances between five and ten years. 30% (12) used between 8 months and 4 years(Table 2.2). Clearly, the overwhelming majority abused alcohol and drugs during late adolescence and early adulthood, critical stages of human development in terms of establishing independence, identity, and a secure place in the world .

Table 2.3 presents prior treatment histories. Most participants (80%, n=52 and 34%, n=22), have a history of prior treatment for drugs and/or alcohol, respectively. These findings demonstrate that participants had access to the addiction treatment system and may have become knowledgeable about the methods employed in treatment programs, i.e., individual and group counseling. A high percentage of respondents (80%, n=52) demonstrate their continued efforts to take some action with respect to their addiction. Despite failed previous attempts this population continued to access and utilize drug treatment services. It may also be possible that past treatment experiences inculcated certain hopeful expectations about the treatment process itself. For instance, participants may have learned the ways in which to use individual and group counseling to meet their particular needs.

Most of the participants treated (87.6%, n=57) had a parent who had been a substance abuser: mothers accounted for 30.7.% (n= 20) and fathers for 60 % (n= 39). A partner was identified as having a history of substance abuse among 56.9% (n=37) of the women (Table 2.4). These findings are consistent with the literature which suggests that children of substance-abusers are at greater risk for developing their own problems with substance abuse (Blume,1990, and CSAT,1994).

TABLE 2

PERSONAL AND FAMILY HISTORY OF ALCOHOL AND OTHER DRUG USE

N=65

	Mean Lifetime Use (years)
Alcohol	9.5
Cocaine/crack	6.7
Marijuana	7.4

TABLE 2.2

RANGE OF YEARS USING POLY-SUBSTANCES

N=40

Length of Poly-Substance Abuse: Alcohol, Cocaine/Crack and Marijuana	Number
8 Months -4 years	12 30%
5-10 years	17 42%
10-25 years	11 28%

TABLE 2.3

PAST TREATMENT

N=65

	Number	Percentage
Prior Alcohol Treatment	22	34%
Prior Drug Treatment	52	80%

TABLE 2.4

FAMILY HISTORY

N=65

	Number	Percentage
Mother Drug User	20	30.7%
Father Drug User	39	60%
Partner Drug User	37	56.9%

Table 3 and 3.2 present a summary of personal history and brief medical history findings. These tables, illustrate some of the consequences of the combination of poverty and parental addiction. Reports of sexual abuse and physical abuse were common among this sample (Table 3). Childhood physical abuse was reported by 67.7% (n= 44) of respondents and 44.6% (n=29) were sexually abused. Violence and trauma in the lives of these women continued into adulthood, evidenced by the fact that 23% (n=15) reported obtaining an order of protection on some occasion.

Women who have experienced sexual and physical abuse have often suffered early life trauma, which has psychological consequences. 11% (n=7) of the sample were placed in foster care during their childhood, indicating parental abuse or neglect (Table 3). 46% (n=30) were incarcerated during their addiction. For some incarceration was part of their process of "bottoming out".

Table 3.2 presents the medical history of respondents. Medical problems requiring special attention were reported by 36.9% (n=24) and 38.4% (n=25) indicated that they were troubled by medical problems in the 30 days prior to entering treatment. The most commonly reported medical problem was asthma. The majority of women had been tested for TB (75.3%, n=49) and HIV (72.3%, n=47). This high incidence of testing was probably due to widespread TB testing in the shelter system and mandatory testing of pregnant women. Unfortunately, test results were not documented in the data system. However, this is a population at great risk for both TB and the HIV virus.

TABLE 3

MEDICAL AND PERSONAL HISTORY

PERSONAL HISTORY

N=65

	Number	Percent
Physical Abuse	44	67.7%
Sexual Abuse	29	44.6%
Foster Home Placement	7	10.7%
Incarcerated	30	46.1%
Order of Protection	15	23%

TABLE 3.2

MEDICAL HISTORY

N=65

	Number	Percent
Medical Problems Requiring Special Attention	24	36.9%
Troubled by Medical Problems in Past 30 days	25	38.4%
Tested for HIV	47	72.3%
Tested for TB	49	75.3%

Many respondents (63%, n=41) had a case pending with the local child welfare

authorities due to negligence charges (Table 4.2). While in treatment with a minimum of one child present, 27.6% (n=18) had one or more children placed in foster care. Recent family conflict was reported by 36.9% (n=24) of the respondents. These findings suggest that the child welfare system is an important system for many of these families, and wields power over them since family reunification is dependent on complying with its mandates.

Some clients (38.4%, n=25) received instrumental support (financial support) from family and friends. This is consistent with findings that suggest poor women with children often borrow money from family and friends to survive (Miranne, 1998).

TABLE 4.

FAMILY AND CHILD RELATIONSHIPS

N=65

	Number	Percent
Child Custody Case	41	63%
Child in Foster Care	18	27.6%
Recent Family Conflict	24	36.9%
Recent Financial Support from Family or Friends	25	38.4%

The reports of psychological distress over the lifetime of the client were high (Table 5). Depression was reported by 33 (50.7%) respondents, anxiety by 38.4% (n=25) and suicidal ideation by 26.1% (n= 17). Notably, 24.6% (n=16) of the women had

received outpatient treatment and 13.8% (n=9) had received inpatient treatment for psychological problems. Given the extent of these psychological problems experienced by these respondents, it is remarkable how few participants received either inpatient (13.8%, n=9) or outpatient care (24.6%, n=16). It is possible, however that access to mental health services was not as available as drug treatment services, and these women therefore never sought and/or received services for their mental health issues.

TABLE 5

PSYCHOLOGICAL STATUS

N= 65

During Lifetime	Number	Percent
Depressed	33	50.7%
Anxious	25	38.4%
Suicidal Ideation	17	26.1%
Inpatient Treatment	9	13.8%
Outpatient Treatment	16	24.6%

The completion rate of the program, 65% or approximately two-thirds, is notably high. Program completion was determined by drug-free uranalysis reports and compliance to individualized treatment plans. The high success rate is even more remarkable given the population served at this program (Table 6). Basic differences between participants who completed the program and those who did not were compared for mean age, mean number of children, and length of alcohol and drug use (Tables 6.and 6.2). Participants who completed the program had a longer period of drug use than those

who had a shorter period of drug use. For example, program completers reported on average 126 months of marijuana use while those who did not complete the program reported 97 months (Table 6.2).

Respondents who were homeless for a longer period were more likely to complete the program (Table 6.3). Length of homelessness was significantly associated with program completion (p.>.05).

Participants who had more than two prior drug treatments were more likely to complete the program than those who did not, although the association was not statistically significant (81% vs.19%; p<0.10; Table 6.4). Again, previous drug treatment experiences may play a role in program completion due to participants' having learned from cumulative accruing benefits of prior treatment experiences. Past treatment also attest to participants' repeated efforts over time to overcome their addiction problem.

TABLE 6

TREATMENT PROGRAM COMPLETIONS

N=65

	Program Completed	Program Not Completed	
Number of Participants	42 64.6%	23 35.3%	65 100%
Mean Age	30	28.8	Range 21-39
Mean Number of Children	2.2	2.4	Range 1-6

TABLE 6.2

LENGTH OF ALCOHOL AND OTHER DRUG USE BY PROGRAM COMPLETION

N=65

Length of Substance Use (in Months)	Program Completion	Program Not Completed
Alcohol	133(months)	116 (months)
Cocaine/Crack	90 (months)	82 (months)
Marijuana	126(months)	97 (months)

TABLE 6.3

PROGRAM COMPLETION BY LENGTH OF HOMELESSNESS

N=56

	Months of Homelessness	t-value	p-level
Program Completed	158	2.51	0.015
Program Not Completed	70		

TABLE 6.4

PROGRAM COMPLETION BY PRIOR DRUG TREATMENT

N=52

Number of Treatment	Program Completed	Program Not Complete	Total
Less Than 2 Prior Treatment	18 58.1%	13 41.9%	31 59.6%
More Than 2 Prior Treatment	17 81.0%	4 19%	21 40.4%
Total	31 59.6%	21 40.4%	52 100%

$\chi^2 = 2.9, df = 1, p < 0.10.$

Several variables were examined to explore factors associated with program completion. These variables included a mother with a substance abuse problem, a father with a substance abuse problem and a partner with a substance abuse problem.

There was no statistically significant association between program completion and having a mother with substance abuse problem (p=.86). However, having a father with a history of substance abuse, showed some association with program completion although the association was not significant (p<.10) (Table 7.2).

Participants who completed the program were also more likely to have a partner with a history of substance abuse (p<.05; Table 7.3). Having a partner with a substance

abuse problem reinforces the "bottoming out" hypothesis, which proposes that having more problems actually leads to cessation of alcohol and drug use (Wallace, 1985).

TABLE 7

REPORTS OF MOTHER WITH SUBSTANCE ABUSE BY PROGRAM COMPLETION

N=63

Status of Mother	Program Completed	Program Not Completed	Total
Mother with SA Problem	13 65%	7 35%	20 31.7%
Mother with out SA Problem	27 62.8%	16 37.2%	43 68.3%
Total	40 63.5%	23 36.5%	63 100%

χ^2 =.03, df=1, p=.865

TABLE 7.2

REPORTS OF FATHER WITH SUBSTANCE ABUSE BY PROGRAM COMPLETION

N=58

Status of Father	Program Completed	Program Not Completed	Total
Father with SA Problem	22 56.4%	17 43.6%	39 67.2%
Father without SA Problem	15 78.9%	4 21.1%	19 32.8%
Total	37 63.8 %	21 36.2%	58 100%

$\chi^2 = 2.81$, df= 1, p.< 0.09

TABLE 7.3

REPORTS OF PARTNERS WITH SUBSTANCE ABUSE BY PROGRAM COMPLETION

N=59

Status of Partner	Program Completed	Program Not Completed	Total
Partner with a SA Problem	28 75.7%	9 24.3%	37 62.7%
Partner without SA Problem	11 50%	11 50%	22 37.3%
Total	20 33.9%	39 66.1%	59 100%

$\chi^2 = 4.06$, df=1, $p < 0.04$

Summary

This section will briefly re-cap the findings from the quantitative data on 65 subjects. First, the completion rate of the program, 65% or approximately two-thirds, is notably high. The success rate is even more remarkable given the population served at this program. The population consists of homeless, substance-abusing women of color who come from substance-abusing and dysfunctional families. Many have been sexually abused as a child (44.6%). More than half (67.7%) have been physically abused as children. In adulthood, 23% have processed an order of protection, reflecting a need to have formal protection from the violence of partners. Every participant has been and is

the primary caretaker of children. In addition, respondents report housing and legal problems, limited formal education and few vocational skills. Fully 45 or 70.8% had no formal diploma, including a GED or High School Diploma. All were homeless, and had a substance abuse problem.

The average age of the sample was 30 years. Age is reported to be an important variable in psycho-social and familial dynamics (Morgan and Kinney, 1996). According to the "maturing out" hypothesis, aging itself motivates cessation of drug use (Winick, 1962). In addition, women in their late 20's and early 30's may be at a point in the development of their lives where they still feel hope for the future, despite the overwhelming obstacles of dealing with poverty, lack of education and skills, familial substance abuse and trauma.

Over 60% (n= 41) of the respondents were involved in child custody cases and 28% (n=18) had children in foster care. This family disruption, affecting both the women and their children, points to the importance of a family-based approach to treatment. Part of the core philosophy of this treatment program was the premise that treating women along with their children would solidify the mother-child relationship and contribute to the likelihood that the women would achieve and maintain sobriety. Given such a multi-issue profile, these women often become the most difficult to engage and maintain in addiction treatment. This program was especially successful in meeting the treatment needs of many women served.

The variables that have been found to be either positively associated with program completion are related to housing, drug treatment, and relationships with significant

others (father and/or partner). These variables may all contribute to respondents reports of "hitting bottom" and being "sick of being sick and tired" prior to treatment. Respondents who had been homeless longer, who had been in drug treatment more times in the past and whose partners and /or fathers were substance abusers may have felt that this program was their last hope (see qualitative findings) and this may contribute to their motivation and successful completion of the program.

Being homeless for a longer period of time was positively associated with program completion. It is possible that having the prolonged experience of homelessness, having exhausted every personal and societal resource, having experienced the humiliations of not having a home, motivated these respondents to remain in a treatment program which assured an affordable apartment upon completion. In addition, many respondents associate substance abuse problems with homelessness and see having an apartment as alleviating those substance abuse problems. It is also probable that for substance-abusing women, a longer period of homelessness also represents multiple instances of securing and losing apartments, due to the dynamics of addiction. Over time, some of these women may have come to realize that substance abuse indeed contributed to the fact of being homeless. Nevertheless, they possessed the internal strength to survive long-term homelessness.

Previous drug treatment experiences may play a role in program completion due to participants' having learned from their prior treatment experiences. It is possible that past treatment teaches certain expectations about the treatment process itself. For example, women who have been exposed to group support and individual counseling may

have learned how to use the group for their stated needs, whereas there may be a learning curve for newcomers to access the help and support they need. The findings here are consistent with the theory of Valliant (1983), who postulates that repeated and sustained efforts over time are necessary to effectuate a meaningful change in the cognition, attitudes and motivation of a substance abuser. Past treatment may also say something about the participants' continued motivation and repeated efforts over time to overcome their addiction problem. This finding may bring hope to both addicts and addiction treatment providers who often view participants' experiences with past treatment as a failure. In fact, it is arguable that multiple treatments indicate a positive prognosis because they demonstrate a respondent's repeated and sustained effort. Thus, it is plausible that failures in one treatment program may be setting them up for later success.

Having a partner with substance abuse problems was significantly associated with completing the program. The importance of these relationships to women are noted in this finding. According to Byington (1997), relationships are important for women, and their addiction is bound up with relationships. Relationships with people suffering from addiction are problematic. It is plausible that having been involved with support systems where others are also suffering from addictions reinforces the "hitting bottom" process.

The following chapter will report the findings of twenty women who successfully completed the program.

CHAPTER 4

QUALITATIVE FINDINGS

The findings in this chapter are based on the data collected from the 20 respondents who have met the selection criteria. Their own words are quoted throughout this section. Excerpts from the interviews illustrate the findings and convey the essence of respondents' experience with recovery. Particular quotations are selected as either representative of the voices of respondents or as a reflection of critical aspects of respondents' recovery process that relate to their continued success of remaining sober.

This section has also required me to look at my own assumptions and understanding while looking at "others," especially poor women with children, whose lives represent a challenge, whose place in the world is harshly judged and discarded. This societal disdain is demonstrated through the public assistance programs that serve women and children, which are considered pejorative, provide low benefits and require mean testing (Gordon, 1994). From a gender analysis, there is a double standard for the provision of welfare to men and women. The most cited example is the difference between social insurance programs such as unemployment, which are more generous and popular, and public assistance programs, such as Aid to Dependent Families and Children, which are stigmatizing and less generous (Abramovitz,1988; Gordon, 1994; Miranne, 1998). Without romanticizing or glorifying the constraints and miseries of life for homeless women recovering from addiction, I hope to convey with these findings the fullness of their experience in maintaining sobriety, and the richness of their multi-dimensional struggle to heal and make sense of their experiences prior to, and while in

the grips of alcohol and drug abuse.

My purpose is to extend and build upon these women's experiences with addiction and their recovery process in order to understand and provide assistance to others who are still suffering from addiction and the effects of alcohol and drugs. I hope to offer a perspective that provides and acknowledges the complexities of experience through the voices of these women.

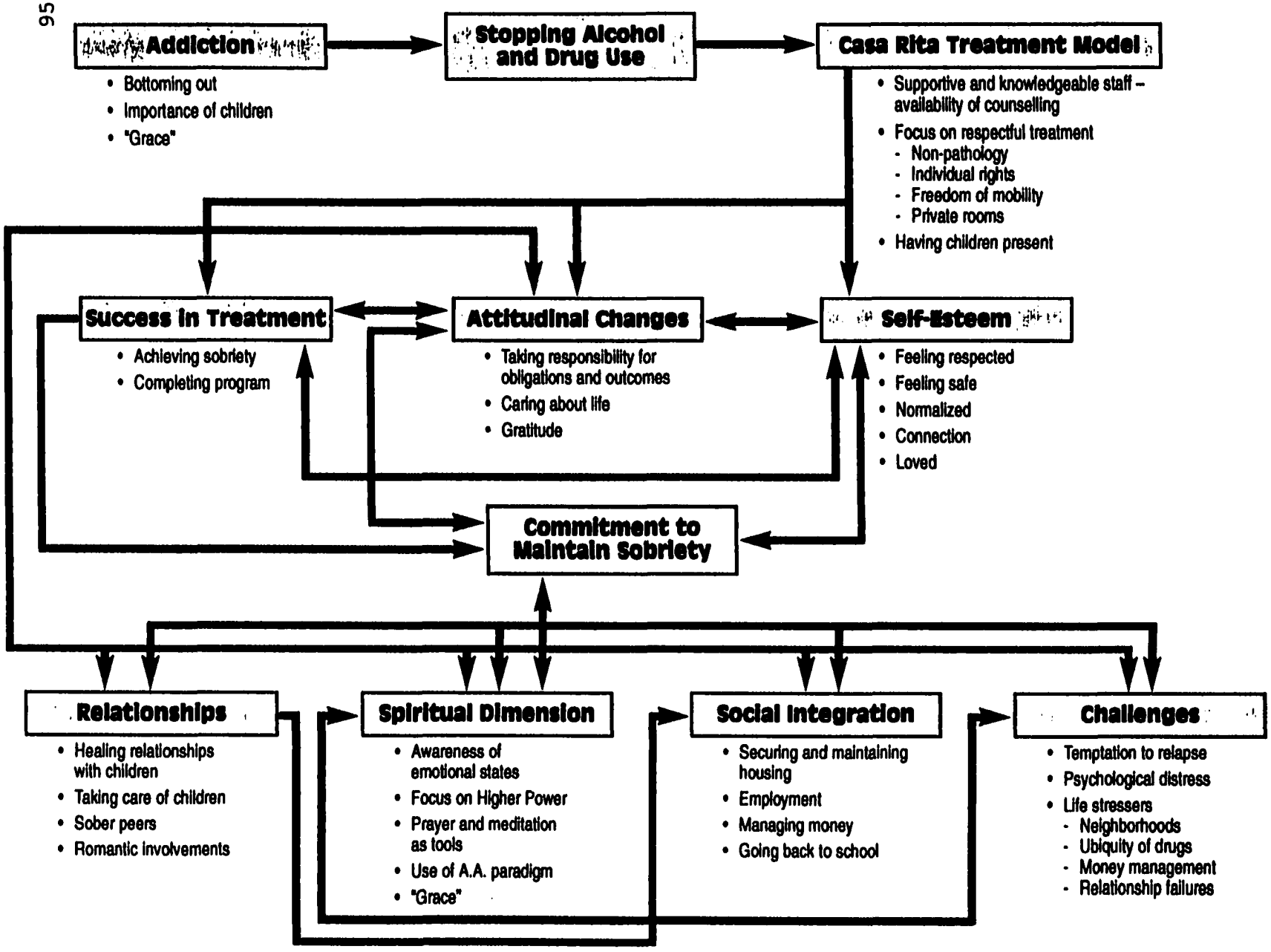
In attempting to appreciate the complexity of the recovery process for these respondents and the interwoven nature of multiple interdependent factors, reference to the concept of non-linear models may be useful. Derived from systems theory (Warren et. al, 1998), linear and non-linear models describe two distinct and different ways in which change can occur. Change occurring through linear dynamics is a straight-line change, where a change in variable A causes a proportional change in variable B. A non-linear process measures the amount of change by squaring the amount of each variable. According to this model, numbers do not increase at a uniform rate, but rather increase exponentially. Moreover, in the non-linear change process, no matter how small the initial change, the eventual effect will be huge. The mere act of seeking treatment at Casa Rita set into motion an interplay of complex factors which led to speedy and dramatic change, simultaneously affecting virtually every aspect of respondents' lives, each of which affected each other. The schemata of the recovery process using a non-linear model is presented in Exhibit 1.(p.94).

This chapter initially includes the basic demographics and characteristics of 20 respondents who completed treatment. Basic information about previous history of past

treatment, initial age of alcohol and drug use, preferred drug of choice and continuous abstinent time are presented in table form. This method of presentation was chosen to give an overall picture of these twenty respondents. The remaining findings are grouped into typologies and themes that have contributed to respondents' post-treatment recovery.

Non-Linear Model (Exhibit 1)

NON-LINEAR MODEL



Characteristics of Client Population

The following six tables illustrate the demographic characteristics of the 20 respondents who completed the treatment program. Age at interview, age during treatment interview, marital status and race/ ethnicity of the 20 respondents are presented in Table 8. The population consists of 12 (60%) between the ages of 25-34, and 8 (40%) who were 35 years and older. None of the women were married. Two (10%) were living with their mate at the time of interview. Eight (40%) described having a significant other, while 10 (50%) were single. Several of the single respondents had lived together with their significant other after completing the program.

In terms of race and ethnicity, 14 (70%) identified as African American, 1 (5%) as White, 4 (20%) as Latina, and 1 (5%) Caribbean.

TABLE 8

DEMOGRAPHIC CHARACTERISTICS OF SAMPLE

AGE AT INTERVIEW	FREQUENCY	PERCENT
25-29	5	25%
30-34	7	35%
36-39	5	25%
40-43	3	15%
TOTAL	20	100%

TABLE 8.2

AGE (During Treatment at Casa Rita)

YEARS	FREQUENCY	PERCENT
20-25	4	20%
26-29	7	35%
30-35	4	20%
36-39	5	25%
TOTAL	20	100%

TABLE 8.3

MARITAL STATUS (After Treatment at Casa Rita)

	FREQUENCY	PERCENT
Married	0	0%
Living Together with Mate	2	10%
Significant Other	8	40%
Single	10	50%
TOTAL	20	100%

TABLE 8.4

RACE/ETHNICITY

	FREQUENCY	PERCENT
African American	14	70%
White	1	5%
Latina	4	20%
Caribbean	1	5%
TOTAL	20	100%

Respondents identified their drug of choice as one of three major drugs: crack/cocaine, alcohol or heroin (Table 9). Of these, fifteen (75%) identified crack/cocaine; three (15%) identified alcohol; two (10%) identified heroin. Those who abused more than one drug (n=6, 30%) identified their secondary drug of abuse as shown in Table 9.2. Marijuana was identified for 3 (50%) by these respondents. Marijuana was used as a secondary drug by those who selected alcohol, crack and sniffing cocaine as their primary drug. Alcohol was identified for the other 3 (50%) of those who identified a secondary drug of choice for those using cocaine/crack (two sniffing and one smoking). No respondent reported crack, cocaine, or heroin as a secondary drug of choice.

TABLE 9

DISTRIBUTION OF PRIMARY AND SECONDARY CHOICE OF DRUGS

	N= 20 PRIMARY		N= 6 SECONDARY	
Drug	Number	Percentage	Number	Percentage
Alcohol	3	15%	3	50%
Marijuana	0	0%	3	50%
Crack	12	60%	0	0%
Cocaine(sniff)	3	15%	0	0%
Heroin	2	10%	0	0%
Total	20	100%	6	10

TABLE 9.2

POLY-DRUG USE

N=6

DRUGS	NUMBER	PERCENTAGE
Alcohol and Crack	1	16.6%
Alcohol& Cocaine(Sniffing)	2	33.3%
Alcohol and Marijuana	1	16.6%
Marijuana and Crack	1	16.6%
Marijuana and Cocaine(Sniff)	1	16.6%
TOTAL	6	99.7%

The age of first use of alcohol and drug use ranges from 8-24 years old (Table 10). Eleven (57%) were under the age of 13 when they initially tried alcohol. Similarly, ten (50%) were under the age of 13 when they first used drugs. Marijuana was the first drug used by all respondents. For five (25%) respondents, marijuana was used prior to alcohol. Ten (50%) used marijuana and alcohol together. One respondent never used alcohol. Interestingly, the majority of respondents (n=15, 78%) used alcohol and 14 (70%) used drugs prior to the age of 16. A total of 18 (90%) used either drugs or alcohol prior to their 14th birthday.

TABLE 10

AGE OF INITIAL USE OF ALCOHOL AND DRUG USE

	N=19*		N=20	
	ALCOHOL		DRUGS	
AGE	FREQUENCY	PERCENT	FREQUENCY	PERCENT
8-10	4	20%	2	10%
11-13	7	37%	8	40%
14-16	4	21%	4	20 %
17-19	2	11%	4	20%
20-24	2	11%	2	10%
Total	19	100%	20	100%

* One respondent never drank alcohol.

The number of years of abuse/addiction for each respondent is illustrated in Table 11. Three (15%) were using and abusing for less than five years, seven (35%) were between 5-9 years, five (25%) were between 10-15 years, 3 (15%) were between 16-20 years and two (10%) identified 21 years or more of use/abuse. Importantly, the years of abuse for this population occurred in adolescence and adulthood, an age range that includes child-bearing years, educational and vocational preparation, and formation of primary relationships with others and self.

TABLE 11

NUMBER OF YEARS OF ABUSE/ADDICTION

YEARS	NUMBER	PERCENTAGE
Less than 5 years	3	15%
5-9 years	7	35%
10-15 years	5	25%
15-20 years	3	15%
21-27 years	2	10%
TOTAL	20	100%

Seventeen respondents (85%) had previous attempts at treatment (Table 12). Two (10%) underwent seven recovery attempts prior to their treatment experience at Casa Rita. Twelve (60%) had between one and three prior treatment experiences, while 5 (25%) had between four and seven treatment experiences. Of the 45 treatment experiences, 12 (27%) were for detoxification. 8 (18%) were outpatient treatment and 25 (55%) included some form of residential treatment.

TABLE 12

NUMBER OF TREATMENT EPISODES PRIOR TO CASA RITA

NO. OF TREATMENT	RESPONDENTS	PERCENTAGE
0	3	15%
1	8	40%
2-3	4	20%
4-6	3	15%
7	2	10%
TOTAL	20	100%

When identifying number of years "clean time" (i.e., free of alcohol and/or drugs), 12 (60%) of the respondents acknowledged 3 years or less of clean time (Table 13). Eight (40%) identified a range from 4 to 6 years sober. Two respondents reported using alcohol and drugs since leaving the program and having to re-count their clean time.

TABLE 13

NUMBER OF YEARS Of MOST RECENT CONTINUOUS CLEAN TIME FREE OF ALCOHOL AND DRUGS

CLEAN TIME	NUMBER	PERCENTAGE
Less than 1 year	1	5%
2 years	7	35%
3 years	4	20%
4 years	5	25%
5 years	1	5%
6 years	2	10%
TOTAL	20	100%

The information provided above clearly demonstrates that this population had been involved with alcohol and drugs for many years. Most respondents experienced a first exposure to drugs during early adolescence. 85% had past experiences with addiction treatment. At the time of the interview, fully 95% had accumulated more than two years of sobriety. Many of these statistics are alarming, and lead to a need for deeper investigation. The factors which give depth and breadth to these findings have been gleaned from interviews with the women themselves, and are presented below.

The following six sections are organized by subheadings which focus on; the factors that precipitated treatment, what participants viewed as helpful during treatment, what works for respondents post-treatment, and how respondents overcome challenges post-treatment.

SECTION ONE

GETTING INTO TREATMENT

Respondents' accounts of factors which led to their seeking treatment are varied, reflecting the unique life histories of each. Still, each woman experienced a moment of realization that substance abuse was a problem. For many, this moment was associated with pregnancy or child-birth. Usually this moment of awareness followed a prolonged period of time living the dissolute life of a drug addict, characterized by crime, illness, jail time and losing their children. The following is a presentation of factors as experienced by respondents.

A) Initial Realization

All respondents recalled a specific time and event in their lives as being associated with the realization that their substance abuse was a problem. For some, this realization gave impetus for obtaining treatment. For others, this realization demonstrated, in retrospect, the intensity of their denial.

Several respondents attributed their realization of having a problem with alcohol and drugs to being pregnant and having a newborn baby. The realization was just the beginning for some of a cycle of addiction. Treatment was not sought until years later.

> Anyone coming home with their newborn baby, you would think they would be home with their baby. Say I got home at 12:00, I was out getting high by 12:30... It took my first pregnancy to know it was not right, it was there, I knew I had a problem, but I never reacted on it. (PB 15)

> My last pregnancy I just did not care. I sniffed with him for seven months straight. When I gave birth I left him in the hospital and I came out to get high. I did not even visit him in the hospital. The other two kids, I never used while pregnant... (GB 7)

Other respondents indicated giving birth provided motivation to seek help for their drug problem.

> I was 6 months pregnant and told I had the virus. I figured I am going to die, let me finish killing myself. But I had my baby and he came out so beautiful. I had to do something. (AB1)

> I realized while I was giving birth I was bleeding so much I thought I was going to die... I was so scared. When I was in labor I was high. I had thought to give him up for adoption. I figured he was going to get in the way of my using... Then at the last minute I changed my mind. (DB4)

> When I was having my daughter, I indulged in it for the whole 9 months. I sniffed the whole time right into labor. The other two I never did that. I asked the lady in the hospital if she knew a place to help me. (TC 16)

Interestingly, studies (Corrigan, 1987; Sandmier,1980) have pointed out that the onset of addiction for women is often associated with a particular life situation or event. Perhaps the same could be true for the onset of recovery from addiction. In the process of becoming mothers, women often experience important changes in relationships with mothers, partners, peers, and children (Brudenell,1996). Conceivably, a woman's relationship to using drugs is likewise affected. Motherhood is commonly perceived as a situation of achieving adulthood. Perhaps, also, behaviors commonly associated with adulthood are now viewed as desirable, i.e., taking care of children and keeping free of drugs. It would make sense for women who do not have much societal power to also view this change as an opportunity to be treated differently by others, i.e., as a responsible mother rather than a homeless drug addict. It is arguable that these changes play a role in the realization that drugs are problematic. Whether or not pregnancy or childbirth hastens the process of stopping substance abuse, it is clear that, for 90% of this sample, these events mark the initial realization that drug abuse is a problem.

B) Precipitating Events Prior to Treatment

The presence of children is one of the most crucial variables in seeking treatment. All of the women entering this treatment program technically had primary custody of one of their children, or was pregnant. Many had family members helping with the responsibility for their children, while some had their children in foster care. The inability of mothers to provide adequate care for their children is one of the most serious effects of addiction among women (McDonald, 1991). In many ways, a woman's care for her children is the motivating force for coming to treatment, and paradoxically, it can

also pose the biggest threat to her on-going custody of the children. Service providers are mandated to report child negligence and/or abuse to local child welfare agencies and the addicted mother thus fears the loss of custody of her children.

In every case, the children or another pregnancy played a significant role that led them to seek help. For a few, this powerful and pivotal variable was also joined to other forces, such as the threat of children being removed or parents being unable to care for their children, jail, homelessness, and rape. Of course, many had already sought treatment but were not "successful" in maintaining abstinence and a drug-free lifestyle.

> Nothing could have helped me. I had been to treatment. The only way I stopped getting high was when I got raped. I left my 5 year old son in the apartment with the door open to go cop on the 5th floor. I got raped, not knowing whether I was going to live or die... I get out of there, crying I run to the streets still going to cop. My 5 year old son comes and out and says "Mommy, don't cry I am going to buy you a nickel". That was it. This was nuts. I went to treatment. I couldn't believe this happened to me, it happened to other people not me. (IB 9)

> In the past, I would go to treatment because I was tired but I always had my mom taking care of the kids. Now she is dead. I was not going to allow the kids to go into the system so it was like get yourself together or else. It was like a roller coaster I was off and on off and on. Hanging out in abandoned buildings. I called a counselor and told her I needed treatment for me and my kids and if I could not take my kids I was not going.(HB8)

> When you're around girls getting high, they let you know ... I knew girls who got their kids taken. They tell you do not use after your 7th month, if they find the baby positive they will take it. I knew I had to get better for my kids because my whole problem in life was that my mother gave me away. I could not see my kids going through the same thing I went through. (GB7)

Precipitating events for some involved pregnancy, children and jail. Ironically, for some homeless women jail is a respite, a safe place off the streets and a place to reflect and detox.

I did not realize I had a problem until I got arrested. By that point I had been living on the streets, abandoned my kids, sold drugs and used. That is how I lived. I get arrested for selling to an undercover agent. I go to jail and I am pregnant. I really feared jail. You hear all sorts of stories. Once I got arrested I was like this is it. I really think it was the fact that I got arrested that did it. I think if I did not get arrested I would be dead or still using. I had time to think. The thrill was gone. Me being pregnant that gave me the initiative to do something about it. (KB11)

I got locked up and I was pregnant with the twins. I did not want to lead a life on the streets. I wanted to take care of my kids. My son was with my mother. I could not imagine having these twins and giving them to my mother. My mother was struggling. I knew I had to get it together. Having twins was special and just great. I believe the twins played the biggest part in my recovery. (PB15)

C) Bottoming Out

At some point, all respondents described "hitting a bottom." Typically, this involved not only the realization that substance abuse was a problem, but also getting to a place where they felt they could not go any lower. Often this involved violating one's own set of ethics or standards. For example, many women described never leaving their children home alone and judging harshly others who did. Nevertheless, in time they, too, found themselves leaving children alone or trailing toddlers with them on cold winter nights looking to cop. It appears that this nethermost place for everyone is different. For some, it could be abandonment of their children, for others, removal of their children, and for still others, jail.

For many, hitting a bottom involved humiliation and/or sheer powerlessness over their addiction. It appears that hitting a bottom may not be an event, but a cumulative set of experiences. It does not happen in one day. It is an endless process of humiliation, turmoil and pain. Many of the incidents narrated in these "bottom stories" were not

occurring for the first time.

For the most part, this group of women had lived on the fringe, moving from one family member's home to another, often seeking shelter at New York City's shelter programs. Some left their children with relatives while they lived in abandoned buildings, and were in and out of shelters. They witnessed murder, robbery, arson, prostitution, and other crimes associated with drug use and dealing. Eighteen (90%) of the respondents had on some occasion experienced a gun pointed at them, although none of them qualified these experiences as "hitting their bottom". Any one of these experiences would seem to qualify as a bottom by most standards. However, life went on and they survived.

"Hitting a bottom" for this group was a euphemism for "hanging out" on the bottom, spending time in an environment where violence, drugs and exploitation were common daily routines. In fact, virtually all respondents "hung out" at the bottom for various lengths of time before reaching a point of motivation and decision to make a change in their lives, i.e., "hitting their bottom." At some point, however, each became sick and tired of being sick and tired, and desired to change. Somehow it seemed that there was now some new element, not present in past treatment efforts, which motivated them to persist. In some cases, a counselor, mother, or child said something that provided a moment of clarity that promoted a desire to get clean. For all those who had prior treatment, this experience or state of "willingness or desire" had not been present before.

It was not like where I came to saying I need help or had a problem. It just so happened a particular counselor asked me a question that rang true at the time. She asked me if I was suicidal. I had so many thing going on. I decided to use the

help.(EB5)

I told her (my daughter) " Look, I am really, really sick. I need to get me drugs. I told her I would make a deal, if you go with me to get bags, I give you my word I will go to treatment." So my daughter looks at me straight and says" yeah I know Mom, you told me that before, you do that and tell me this and that, but you do the same thing..." I felt a spiritual thing with her and this time we both knew I meant business and this time I was serious I was going, I meant it. (XB19)

BCW told me they were going to take my kids, I really did not listen. But that Sunday I went to my Moms and she said "Oh my God, look at you". The way she said it. I told her I need help it is not that easy to stop. The next day I got help.(DB4)

While at the pregnant shelter they found out I was using. They made me go to the outpatient program. Every time I went I had dirty urines. The counselor said "Either you want your baby or you do not, if you do, you got to stop getting high". I said "find me an inpatient program I will go tomorrow". I was tired. I liked the high, but I was all alone sick and tired. I was not going to let them take away my baby. I never thought I would get my other girls back. (FB6)

SECTION TWO

STAYING IN TREATMENT

A) Importance of Having Their Children

Every respondent reported that the ability to have children with her in treatment provided motivation to enter and stay. During treatment each respondent, had a minimum of one child, the average was two, and the range was from one to five children. Nine (45%) respondents had all their children with them during treatment. Eleven (55%) continued to utilize familial or societal resources to help care for their children. Of those, 6 (55%) of the respondents continued to have children reside with the maternal grandmother or aunts. One had children in foster-care. Two respondents had children

who were in the custody of the biological father. One had a child in jail, and one in a long-term residential medical facility.

Most expressed the view that having their children helped sustain motivation in the recovery process. A part of the recovery process is dealing with past behavior concerning children. Motherhood is central to many women's identity and is often the source of much anxiety and guilt. When substance abuse is added, these feelings can be magnified and intensified (Finkelstein & Durman, 1991). Having their children with them often contributed to an awareness of the dire urgency of coping with recovery issues. In some cases, the presence of their children helped to re-establish relationships and to deal with the guilt associated with them.

> The fact I was there with my kids helped me. It is important to me to be a good mother, that's what I want to do. I had so much guilt, you cannot erase the past but you can do things the right way in the future. (DB4)

> I begged my mother to let my son come to treatment with me and she did, my baby was with me. I needed those kids, I needed to get to know them all over again. My oldest one when we are walking on the street he hugs me and says "I am glad your not like that anymore I am proud of you." That right there just clicks it all. That right there is so good it is better than any high. After all I have done to these kids. (TC16)

> CR was the only place that sees women with kids. It was important to have your kids. How could you separate a women from her kids because she is sick. A lot of times women need their kids to help them come back to reality, help them to cope, come back to the way things should be. I did. (BB2)

> When they told me I could bring the kids I knew I could do it. All I did to my kids, my family I could face it if I was with them. I have these kids. I have their emotional life in my hands and these kids they taught me. (LB12)

> My first daughter I lost, she got adopted without me knowing about it. I never knew I lost my parental rights. I knew if I stayed in CR I had that chance of becoming a mother, the mother I wanted to be. It was totally different, to look around and see 16 women with their children....You have to deal with your past.

Truthfully, that (meetings) does not keep me going, what keeps me going is the bond with my children. (NB14).

Interestingly, the child care program was viewed as essential but problematic in that the space was inadequate and financial resources were limited. Many women cited the importance of on-site child-care. They described the need for a break from their children while they attended to their treatment activities . It took time for some to feel comfortable leaving their children in daycare. Respondents cited health standards and cleanliness as major problems of the child-care program, inevitable given the budget and space constraints.

At first I did not trust leaving my kids but I had to because I could not bring them to group. It took awhile to feel OK about leaving them there. It was on-site and that helped. Nobody ever had to tell me to go get my kids. Once I finished my stuff, I went and got her. (HB8)

I found it great. It gave me a chance to be away from my children a few hours and a chance to get into myself. I did not have to worry about my kids. (FB3)

The child-care stressed my children out. They were always getting pink-eye, sores in their mouths. The place was a mess. (PB15)

I did not like it. It was horrible. My son was too big. He would be down there with the little toddlers. They should have had two separate spaces for the bigger and younger kids. Every time someone had a child coming out of there with ring worm or something.(ZB 18)

The child-care was good. He met other kids and before he was the only small kid in the family so he was never around kids. I think it was good for him to be around other kids. (DB4)

The teachers were good. It was just the hygiene. It depended on the mothers (referring to dirty children and dirty clothes). It could get nasty and dirty.(IB9)

B) Staff Attitudes

The positive attitudes of therapists and helping professionals can have an impact on the engagement and prognosis of a client. Counselors and social workers often have difficulties in engaging and treating addicted homeless women with children. These difficulties can be attributed to societal factors that blame, stigmatize and stereotype these women for the problems of society itself (Sidel,1996). Stories of human suffering, when it appears to be self-inflicted such as addiction, are often met with judgement and criticism.

Respondents described non-judgmental attitudes of the staff as providing a safe atmosphere to heal and recover from addiction. The importance of sharing experiences and personal stories in an atmosphere of support is critical to the recovery process (CSAT, 1994).

A common technique employed in addiction treatment is confrontation. Some women described experiences with this approach which left them feeling judged and misunderstood. Many described the treatment by staff at Casa Rita as very different from treatment at other programs. The Casa Rita philosophy viewed confrontation as counter-productive to the growth process. Nevertheless, speaking directly and truthfully about behaviors was a part of the gestalt of the treatment process. Interestingly, behaviors associated with a client's feeling respected by staff included; listening without interruption, talking directly without yelling, and receiving comments and suggestions. Moreover, since clients felt they were not judged and were respected, they said they experienced being understood. Finally, respondents expressed appreciation of the woman-focused orientation of the Casa Rita program, as evidenced in the quotes below.

There were wonderful and good counselors. They did not baby us they were not telling us what we did while we were out there was OK. They treated you with respect and made it OK to talk about it, stop blaming yourself and believe in yourself. They knew how you felt. (TC16)

It was more family like. I loved that they did not judge me, everyone judged me before going there. They gave me respect they listened to what I had to say. They did not judge me . They made me feel like a woman, no matter what I did in the past it was something they did not judge me or make me feel nasty. (FB6).

I felt there was more respect at CR than--- . There was always the screaming and the hollering and haircuts (used as punishments in TC treatment). In CR they sat down with you talked to you... I could talk to them and they would actually sit down and listen. I think it really helps if they know what is going on and what your going through. Staff were able to identify from their own lives. (CB3)

There was no judgement we were all the same. You could not manipulate. I can not explain it they helped me so much. They cared, they loved, they knew and understood every feeling. They did not interrupt me and tell me I was wrong or stupid.(GB7)

C) Counseling

Individual, group and family counseling were described as important aspects of treatment. Eleven respondents (55%) reported a combination of individual and group counseling as most helpful, while 6 (30%) reported individual counseling. One (5%) reported a combination of individual and peers, one (5%) family therapy and one (5%) self- help meetings as most helpful.

The importance of individual counseling was highlighted by a majority of the respondents. For many, the individual counselor provided time, support, and understanding that enabled them to address feelings and situations associated with their on-going recovery process. Although not a sanctioned practice, it seems that on occasion, a counselor was willing and available to extend the boundaries of the traditional

counselor/client relationship, and be available for open-ended sessions or for telephone contact outside of session time. Many respondents cited the importance of having a counselor available in this way. Similar to some therapists in private practice, the counselors were perceived as being available and on call twenty-four hours a day. Different from private practice, participants viewed counselors as being available to listen for hours at a time.

My counselor would let me talk and had me learn how to trust her... I was able to let her know how I was feeling, how I was doing she gave me trust. She gave me time.(CB3)

The individual counseling helped the most because I can talk more one to one than I can talk in a group. (HB8)

I could talk more freely and had more attention. Anytime I could call my counselor 24-7. If something went on I could call her that was very important, she extended herself to the max... She helped me deal with my grandmothers death.(IB9)

I would have my individual sessions and they were great. She knew me I held a facade with the other women, being I had the virus and I had a girlfriend. She would listen to me for hours and tell me I was going to be alright. (LB12)

My counselor always made me feel that I was special and that she saw something in me. I could do better. She planted that in my head. She made it OK to talk about it and stop blaming myself. I don't know how she did it. She made time for me. She was there for me.(TC16)

Some things I could not discuss at first in group. It was important she gave me the time to talk about things I could not discuss in group. I got very good advice and she gave me good sessions. (NB14)

D) No Holds Barred

Many respondents described the importance of being able to talk about anything and everything as part of the recovery process. Given the dehumanizing experiences of

addiction, homelessness, and violence (family and societal), these women struggled to cope with their complex feelings of rage, guilt and inadequacy. Sharing their history with others was an important healing component that helped them to cope with the trauma they had experienced and to bond with each other. Through listening to others and building relationships with their peers and counselors, they were able to identify their feelings of guilt, shame, inadequacy, and fear. For most, life experiences included rape, incest, sex-abuse and other traumatic events. Many described the importance of having an all-woman program which enabled them to feel safe and deal with their issues.

I could not get with it at first- all girls. I did not like aggravation but I learned from them. It was safe. I loved it you get it out of your system. Because no-holds- barred you said what you felt no holding back. You learned how you felt. If we brought it up you had to handle it that was that, anything went I mean a lot of us did do some crazy stuff. It was between us. It is a part of the recovery. (HB8)

We were human beings that went through struggles. I loved that we went in- depth about our past, our families, problems from childhood, molestation, sex abuse. I felt that no matter what any of us went through we respected the fact that we were trying to better ourselves and do something for our children at the same time. That meant a lot to me and gave me the initiative to open up and talk about what I went through.(KB11)

The fact that it was all women helped because it gave me a chance to look at myself. Particularly since I did not get along with women. I worked out my differences and the reasons why. I needed everything, all the groups, my counselor, friends I needed all that structure. I do not think I would have the closeness I have with my family. I would not know how to advocate or speak to someone after they hurt my feelings or created feelings in me. I would not have female friends. I had to get it all out while I was there.(NB14)

Everyone had a deep secret and it was powerful. My deep secret was about my son who died in childbirth and my mother's child abuse. She would beat me in the middle of the night... She would give me welts. Others had their secrets. One, their father raped them but really, she would be so high, she would throw herself on HIM, another left her baby with a friend and he killed her. God, what we have been through but somehow talking about it healed us. It bonded us.(UC17)

E) Having Space

A few respondents felt that having the freedom to leave the residence to attend to other appointments and activities was important in their decision to remain in treatment. This freedom of mobility constituted a key difference between the Casa Rita program and traditional TC programs. The freedom to leave the residence reduced feelings of "being locked- up" and punished. At the same time it may have fostered responsible decisions while reducing the resistence of residential treatment. Levinson (1985) suggests that for substance abusers who are ambivalent about treatment, a counselor's willingness to allow space and some psychological distance can enable continued treatment. While it was not the experience of any study participants, it is arguable however, that the policy of unfettered mobility may pose increased risks of relapse to respondents who re-visit old places associated with drug use.

It was important that they allowed me to go to doctors and clinics outside. They let me take care of my business.(UC17)

It helped me that they did not pin me down they gave me some space. Either you do it or you don't.... It was my own place I had my own room, I could pick up money from the check cashing place. I could go shopping. It was up to you.(PB15)

I was always wanting to go out. I would go out and not get high but I would go back to those places where I should not have been. Finally, I decided not to go back to those places it was something I had to do. I had to have the freedom. (MB13)

SECTION THREE

REMAINING SOBER

The factors contributing to the maintenance of on-going sobriety were remarkably

similar for each of these respondents. The factors and themes that are identified in their recoveries are related, sometimes co-responsive to each other, and in the aggregate serve to form an interwoven fabric of life in recovery. No one factor can be separated from the whole. Indeed, in these women's lived experiences the sum of the recovery factors comprises a synergistic effect, i.e., a value larger than the sum of the parts.

Again, the concept of the non-linear model serves to best illustrate the interconnectedness of the factors in the ability to maintain sobriety. Respondents report that the keystone to remaining sober is relationship. Given the relational nature of women's life organization in general, this is not a surprising finding. First and foremost, respondents credit relationships with their children as important to maintaining sobriety. In addition developing and maintaining relationships with sober peers is an essential component of remaining sober. Sober peers serve not only as sources of support but also as continual, relentless reminders of the importance of maintaining sobriety and the tools required to do so. Finally, committed romantic relationships, usually with a sober partner plays a key element in these respondents' ability to maintain sobriety.

A) Relationships: Children

All respondents described the relationship with their children as very important to their continued sobriety. Many are very proud of their children and their accomplishments. The children have been a source of hope. Many respondents hope to raise their children differently from how they were raised; they hope to teach their children, have a relationship with them, and talk to them. They hope that their relationships with their children will provide them with enough support to sustain them

through their own challenges and development.

When my son's teachers call me, I feel like I am going to burst with things they say about him. He got the whole class interested in science, he is great. He is getting ready to be tested for a school for the gifted. The teacher calls to let me know whatever I am doing to keep doing it. The pride of something like that, it is wonderful. I am sober and clean. I can do this. I am not fucking up. I am so proud of him. I cry at all these award ceremonies and he snatches me and tells people this is my mother.(GB7)

My kids are good. My oldest just won a spelling contest. I am so proud of her. I have to keep them from getting into trouble. I could not talk to my mother as a kid and I am not going to let that happen with my girls. There are a lot of ways I will not treat my children. They can and do talk to me about everything. I explain why I am doing what I am doing. I love them all and I am too attached to my miracle baby. (FB6)

My kids, their future, it's important to me. I want them not to be addicts, that is scary for me. I am raising them differently than the way I was raised . I teach them what can happen to them. I did not know anything. My parents were from Puerto Rico. I could not talk to them. (JB10)

Some women described the difficulties of re-establishing a relationship with their children and adjusting to the role of mother. For some, returning children posed many challenges, along with rewards. Some of these challenges included issues involving drugs, school attendance, and trust. Many described praying for patience and tolerance.

What an adjustment we went through. Him thinking what I say is a joke. He did not listen... Lets get real. He goes to school when he feels like it. He never liked school. He might get six credits a year. I just hope they do not put him out of school. Now we talk, he knows I am HIV. He helps me to take the medicine and then tells me I be bugging that he thinks it's from the medicine. I like the relationship I have with him... I pray all the time for him. (AB1)

I have to be patient. Many times I want to wring their necks. I had to remember they had to get used to being here. I had to get used to them being here. They did not know whether I was going to pick up again and they would have to go back to grandma's house. I learned to talk to them, make them feel they can talk to me. I think I am raising them differently than myself by letting them talk about how

they feel...I often was ready to hit before I listen. I pray for patience. I just busted my oldest for smoking pot. I was mad. My boyfriend talked to him. He said he was sorry. He is not the smartest. I am so glad he is in Catholic school. I try to talk with him and tell him what I have been through and then I start to scream. But I want it better for my sons and they are able to say to me what is going on for them. (CB3)

I am surrounded by love. Once my son said to me when he was 16 years old that if there was a law he would have divorced me. He hated me. He really could not stand me. He could not trust me. Now he trusts me. That is very deep and important. (DB4)

I had to adapt to a few changes. I had to get to know him and he me. I had to re-establish our relationship. He respected me but would see me more as a friend than his mother. Sometimes we would get into a dispute and he forgets I am his mother and not a friend in the streets and I would have to put him in his place. I am open. We talk. I feel my kids should know everything, sex, drugs, what is going on... I pray every morning and every night.(KB11)

Many respondents described fears of their children becoming addicts. Some were already dealing with a substance- abusing adolescent or young adult child and found the struggle more than they could handle or perhaps handle alone. Others were dealing with children who had special needs. Often, the hardest challenges and the most difficult situations were the child's special physical and psychological needs resulting from life-long deprivation. This promoted a profound conflict for the mother who attempted to balance her struggle for sobriety with helping her child. For a few, the realization that their children were suffering direct consequences of parental addiction was complicated. Although a constant reminder of the harm done, these children also provided a deep motivation to maintain sobriety.

My son is supposed to come home from addiction treatment, but he is acting out. Tomorrow we go to court, if the judge releases him, he comes home but the drug treatment will have the final say. I am down with them... I want to give him to

some men in the fellowship. They are going to help him. I cannot do it. I am too close to sponsor my child. For a while he was coming home on weekends, and we all were adjusting, living together... watching movies and I have made plans to take him to the young people's convention. I remember 19. God knows it's a hard age, some kids are leaving and mine will be coming home. He has seen it all. I can only keep sober. (ZB18)

My one son has a speech delay. Everybody in the world can tell me it is not because of drugs, but I know it is and believe me, I do not forgive myself. Everyday I can see, feel it. You can see he does not speak well. Thank God for early intervention, so now he does speak. I know the effects of crack on kids, I read. He gets hysterical over the littlest thing... God loves me and blessed me. God wants me with these children... My kids deserve a mother...You have to have patience... I have learned how to go in and meditate and calm myself ...I do not pick up (alcohol or drugs). (YB20)

I did not plan on these kids having so many problems. I thought I got over when I got them out of the hospital, but once they started the school process, people were like we can not keep them. I was in denial like there was nothing wrong with them. My 8- year old is already a size 10 shoe and 170 lbs; he is psychotic: hearing voices, having us all up all night. It affects the whole family....Now I am beginning to see the damages as they grow. They are being helped and me, too. At first, I had a hard time with the special school. I wanted the best for them. I broke down and explained to them(the school) to do it right, because I put them through hell and I want the best for them.... You see, kids work with you. Now I can tell them," do not talk to me at the same time. I get a bad headache, "where before I would say " I am going to choke the shit out of you if you do not shut up". They're like "oh you get a headache," and they calm down. They do not want to be talked at, rather talked with, like us....When they wake up, I want to be there...I want to be a part of their lives and I want them to know me.. Be able to look into my eyes. This home is my work. I have five kids. I have this responsibility. I love my kids.(LB12)

I pray constantly, me having children and never dealt with them before I have to. I need to pray for tolerance, Patience. Now my boys do not know me. I do not know them. I have to pray. They are both speech delayed, hyperactive and learning disabled. They are only 4 years old. My daughter has the same disabilities, but she has been with me since day one so we have a different bond.... As time goes on, I know- I will, they will trust me, and I am going to feel the same way about them. I look forward to the weekends with them. We do things together, go to the park, the library. We plan things. They will be returned permanently this fall(NB14).

B) Relationships : Romantic Partners

Of the 20 respondents, 18 (90%) reported being in a current or recent relationship with a mate who was in recovery from addiction. Only one reported being with a mate who did not have alcohol and drug problems, and one reported not having a post-treatment romantic partner at all. With respect to sexual orientation, fourteen identified themselves as predominately heterosexual, while four reported their sexual preference as bi-sexual and two identified themselves as lesbians.

All of the current relationships were cited as being very helpful and supportive to respondents' continued sobriety. Of the nine in a current relationship, eight are involved with people in a recovery program or self-help program (i.e., A.A., N. A.). Since relationships are important for women, and indeed, an addiction is a form of relationship, a healthy relationship with a partner can be an important factor in healing (Straussner, 1997). Having a supportive partner was described as serving many functions; affording private space while remaining connected, providing help with the children, making possible shared talk and activities, affording help with paying bills, and normalizing ambiguity about sexual preferences.

My boyfriend, he helps me out. He takes care of the children while I go to meetings. He does not bug me when I need to talk to my sponsor, he will take the kids in the other room or let me meditate... He is good . We talk ,and when I was using, I would never talk to him. Now I talk. We sit, we conversate, we go places, we have fun. We go to the movies, out to eat, even sex is better then before... He will give me money and pays the bills. (TC16)

I have support. My boyfriend he is in recovery. He helps and knows the story...He is a real good guy. We talk all the time and what helps is that we are both in recovery. So if he gets on my nerves, and I need my space, I tell him to call his sponsor, get out of my face. Leave me alone. I get up and close the door. We have

space in here. He shares everything. He is off on Thursday and Fridays. So we go out with the family on Thursdays and stay home on Friday nights... He is old fashioned. He tells me to stay home . He makes enough money, but this is not the 1950's. I work, but do not get enough hours. I love him. But I think if society did not look down on being with a woman, I would be with a woman. But I have kids and for my kids' sake it's best to be straight. He knows I have been with women. He is OK with it. I love him... He is a really good guy. (BB2)

He is in recovery. He got sober before me. I met him at school. He does not pressure me like getting his name on the lease and the keys, like the last one. He works, we talk. He helps with the kids. This time around , I am going to wait before he moves in to make sure it's right. (CB3)

She is in recovery ... She is a great support, she made me feel so relaxed. She loves my kids. Her kids are grown. After I got to know her, I did not care what others thought, the hell with them.... She helps me with my HIV issues and I help her with her recovery issues. I go up to her house and it's paradise. I will be like, " kids, what kids?". It helps me to separate from my kids.(LB12)

Only one respondent reported being in a relationship with a non-addicted man. This relationship was viewed as very supportive and helpful in the respondent's recovery process despite the stress in the relationship resulting from the partner's infidelity and in fact extra-marital paternity which occurred during respondent's treatment.

God bless him, he would come and pull me out of the drug spots. Take me home and I would use again...He never left...Me and him went through something. He had a baby with another girl while I was in treatment. I fell apart... and that child is his. It is awkward. Trust is having to be rebuilt. I have trouble trusting him. We have kids here now they have a half sister. I let him go see his daughter. He asks me but I am not there yet to let her come here. I know it has nothing to do with the child, I am just not there yet... He is a great help. I can talk to him about anything at all. He has a good job. He is in the union as a construction worker. He pays the bills. He wants to get marred and move to N.J. I am not ready to marry him yet. I try to get him to go to counseling but he is not into it. (GB7)

C) Relationships: Sober Connections

Every respondent cited sober peers as sources of support in remaining sober. In

this case, respondents specifically meant their colleagues in treatment at Casa Rita. For many, the social network of friends then expanded to include other women who went through the Casa Rita program and newfound sponsors and friends in their local A.A. or N.A. meetings. Sober friends provided emotional support and a connection that assisted them in maintaining sobriety. Many suggested a comfort in feeling free to be themselves among friends who shared the same problems and desired to remain sober. In so doing, they described feeling supported and "connected." Typically, the need for sober connections was so intense that an unusually large network was experienced as desirable.

My friends, I have people who love me unconditionally. They call me in the morning 6:00 a.m.,2 p.m, 11 p.m. on a regular basis. They tell me things like "I love you, I know you do not love me, but I love you anyway. Did you make your meeting? ". They check up on me. The people I have in my life today, I could not trade for drugs. All my life I looked for love...I can let my hair down, take off the mask, this is who I am. They do not judge me. They understood. I do not ever feel alone going to a meeting. I may be going through something and all I have to is listen because there is usually someone going through the same thing. So it lets me know I am not alone. (XB19)

Basically my friends and family stand bye me. I pick up the phone and call P---. She always says something that helps. I let whatever is hurting me out, I call G---, S----, P---, I really rely on my sober friends. I talk with them at least once a day. With P--- she always makes me promise her that at anytime I feel like picking up before picking up I call her. (DB4)

People have been put in my life to keep me sober. I have 3-4 people I call from CR and I have friends at the meetings and sponsors. Only the people in A.A. can I ask for help. Someone is always calling on the phone and saying you want to talk here. I have five home-groups. (ZB18)

I have a lot of support. I love this work. I have my own family . I have my sober family, I have my HIV family. You know I am loved all the way around. I call everybody. I have a lot of friends. I call that one talk with her for two hours, than I call that one with the same problem than I call the next one, I do it everyday. I get depressed I call a friend... That's the purpose of the call so I do not pick up. (AB1)

I stay connected, as long as I stay connected I will be OK. I keep in touch with my sponsor regularly. Its hard to go to meetings I am going to school... My sober family and the positive people around me It is just the people. It is important to have a family especially if you do not have a family you got to have a family... staying connected with sober people. (HB8)

Many respondents discussed God or a Higher Power as a source of support in remaining sober. Some felt they were given a second chance at life. Indeed, many described an "attitude of gratitude" at having the chance to live life differently. Many prayed daily to thank the God of their understanding, and to ask for help to continue with their sobriety.

A big thing is God. I believe there is a God. I am not supposed to be here today. Praying to him even though I do not really know how to pray to him. I just say whatever comes to my mind... If I pray and turn it over to God I know it will get better. One I have to keep praying, two not pick up, it will always get worse. One is to pray not to pick -up. (CB3)

I pray every day. I keep my "Daily Word". I read the literature.... Without God I would not be where I am right now. Without God, forget it. I thank Him every day. (HB8)

God keeps me sober, he puts people in my life to keep me sober. He is the ultimate there is no doubt in my mind. I have been given a second chance. I have healthy fear. Healthy fear, fear of betraying God one more time, that would be the ultimate sin, Since, He so generously brought me out of that kind of life. I t would be a spit in His face and I am not going there.(ZB18)

If I were to go back there I would die. I was terrible, mean, nasty, I would rob you. I do not want to die like that. I can not get high unless I pick -up. I am not going to. I pray all the time.(PB15)

SECTION FOUR

CHALLENGES IN RECOVERY

The issues which impacted on respondents continued recovery included external

environmental conditions, relationship stress and money challenges. Money matters were the first factor identified by respondents as presenting challenges to recovery. While common to all poor, and not just addicted women, these challenges nevertheless triggered worry, fear, and temptations to use substances. Relationships were also cited by respondents as providing not only support but also challenges to recovery. Dealing with the inevitable ups and downs in relationships posed difficulties for respondents. As part of a non-linear model, the factors constituting challenges and responses to them cannot be isolated, for they are inextricably connected. Environmental factors and situations might, for example, trigger emotional states, challenging an ability to cope. In an attempt to self-soothe, thoughts of using alcohol or drugs might arise. For example, hearing gun shots in the neighborhood may bring up feelings of fear, sadness and anger, and could well trigger early childhood wounds related to violence, abandonment, incest and/or physical abuse. A telephone call to a sober peer may provide the support to cope with issues that were previously alleviated by alcohol and drugs.

A) Money Matters

Overwhelmingly, the respondents are women of color, who are primarily responsible for their children and are raising them with very limited incomes. Despite their hard work and best efforts, the amount of money they earn is often below the poverty level. Arguably, such minimal financial resources may have contributed to the initial appeal of drugs. Even respondents who worked full-time also continued to receive some assistance-- rent subsidy, Food Stamps and/or Medicaid -- since their full-time jobs paid close to the minium-wage ($ 5.15 per hour). Thus, daily expenses such as baby-

sitters, transportation, electric and telephone add stress to their lives, and can trigger emotional difficulty. For some, feelings of frustration, anger and rage are closely related to meeting the daily challenges of raising children on limited income.

Many of their issues were related to the ordinary but seldom articulated challenges of all poor women raising children; low wages, high rents and child-care costs. Money issues often triggered fear, depression, and panic. Still respondents maintained a positive attitude toward managing money, and a determination to achieve mastery of their limited budgets.

Since I got off of public assistance I have to pay my own rent, and it got to the point it stressed me out. I work at Kmart... I was crying and I am hurt, the bills are coming in and I got to pay the rent... I pay the babysitter. I cannot loose this apartment and I am so stressed out.... Every six months, they do this face- to- face with your pay stubs and stuff and see if you are still low-income and if you're not they may cancel your lease or make you pay a lot more. I t is so hard...,so hard. When you come home there is always something a book, a birthday. It may take two to raise a kid but I am on my own, but I will be darned if I am going to lose the job. I feel good. I am not on the system but it is hard. (DB4)

I work...I stress myself out to a certain point like a bill. I pay the bills. I can be broke and not have a dime as long as I have carfare. I know another pay check is coming. It feels so good being responsible. It feels so good... So good. I have Con Edison, rent -section 8, telephone, insurance for my kids and I dress them as best I can... I hold back on one bill every once in a while and treat the kids. We deserve that. Then I catch up...that is the stress.(KB11)

Just last week I was cut off of Public Assistance. I am a home-health aid. They said I was making too much money, but I might be still entitled to medicaid and food stamps. I have section 8 , my landlord is asking for $1004. But Section 8 only pays $821. So my landlord lowers the rent to $821 with the understanding that I have to move to a smaller apartment if another apartment becomes available. In the midst of all this, I did not know welfare stopped paying their portion of the rent, so now I owe $ 777. I have to wait for the dispossessed notice and then Section 8 will make me a budget and I will be obliged to follow that. You would think if the landlord knew I owed him all this money, he would have said something. (CB3)

The bills get me lonely and depressed because I am doing this by myself, me and three kids and a part-time job with a little help from welfare. I tell myself it is going to get better. I had this dream job. It was a government job, training me to be an accountable property officer, my own desk and phone and $13.00 an hour. I lied and said I was never arrested on the application. Two months into the job they took my finger prints..if I did not lie I think I would still be there. They said "we have to let you go it is the law you are on probation for possession of drugs." The point was I lied. I would not do that again. I will put yes. I learn from my mistakes. I cried so hard . I was so hurt and crushed. Now I work at K-mart it is like a family. I will get a raise soon for being there a year .(FB6)

Money was also mentioned as a "trigger" for some who associated money with drugs. Money provided the ability to buy drugs and therefore induced feelings of being out of control. For some," too much" money could be an unwelcome challenge.

My trigger is money and on the job each week I handle a lot of money. I tell my supervisor "money is a trigger for me"and she told me"anytime you need help call me." Recently I got an income tax check, I asked my niece to go with me to cash it. I was real rude with her. I was real scared. I apologized but she had no idea that money is still a trigger...I am responsible . I pay the bills. But money is my biggest trigger.(AB1)

My oldest daughter got an income tax check and she gave me $1000. I was sick the whole day . I took the kids out to eat and to the movies. I did not know that amount of money for me was a trigger, that evening I told friends I could not eat all day and I got all this money and I do not know what is happening to me... I gave it back to my daughter and told her to put it into the bank.(XB19)

B)Relationships

Romantic relationships were a mixed blessing to many of the respondents. In addition to providing love and support as discussed above, these relationships were also the source of anger and frustration, adding one more challenge to this already burdened population. One issue often mentioned involved control: these women did not want to abdicate part of their lives to any romantic partner. Other issues facing the respondents involved: coping with the HIV virus; death of an ex-husband; and coping to a mate's

alcohol and/or drug relapse. Moreover, respondents often expressed ambivalence about romantic relationships, and placed their relationship with a higher power above their relationships with partners.

There was this relationship that shot me down. I was not looking at some facts, even though he was sober ...It was so much stress, it was like he stabbed me. I was hurting so bad. We are still involved because it is our child. I want him to stay out of my business. I want him to see and visit our daughter but I do not want to answer the questions he poses. He left me, now he is always going on about who I am with...I wanted to pick up(drugs) after him. I feel I got to leave him alone, he got me to the point I wanted to use...He has a problem of keeping his thing in his pants and knowing who his girl is... He stressed me like saying how he liked the girl so.
(HB 8)

I get lonely and depressed I need a man ... I had one but he was not for me. He came and lived here with me he was sober and all . But I felt he was suffocating me. I felt like I needed air to breathe. I miss him now. He went to Texas. I ran him there, he wants me to go there. He is still a good friend. It could have been my shit but I wanted him to leave. He is a good man, my kids loved him. I just had to go and mess it up. But I have to trust my Higher Power has another plan for me.(FB6)

My boyfriend moved in with me right from Casa Rita. I should have waited, everyone told me to but I did not... Of course it did not work out because I have control issues. This being my first apartment I wanted it the way I wanted. Also, even though he was sober for 6 years we had differences. What was important to me was not important to him. I needed my space. It was hard to tell him this. I was co-dependent on men. I feared I could not pay the bills. I knew welfare would only give so much. I need to stand on my own and that is what I am doing now... I had to verbally abuse him to get him out. Now we speak on the phone.(NB 14)

I had a nervous breakdown. I was so scared I thought I would relapse. I could not get up -I could not get out of bed. Everything happened to me. My ex-husband was pronounced dead in the Persian Gulf. I start getting all this money from the government. I used to take our kids to the cemetery. One day I go to the bank and there is no money. I come to find out he never went to the Persian Gulf he betrayed his country and is now in military jail. In one week I find this out, along with finding out my boyfriend whom I live with has the virus. He was deteriorating. I could not cope. I drove my boyfriend crazy, but he is OK now.
(IB 9)

I always get the damn losers. It is a pattern. I control them and mold them the way I want them to be. .. either they back off immediately or they hang around for awhile and then leave. I am the boss. I pay the bills. I call the shots. It is my apartment. My ex-boyfriend picked up. Even when he was sober he could not maintain a job. But we were going to marry. It is best we did not. It was painful. We had planned to marry on my son's birthday. I bought the wedding dress. I have had to deal with so much. My son's father gave me the virus. Now he relapsed.(AB 1)

SECTION FIVE

RESPONDING TO CHALLENGES

The ability to respond to challenges and stress without the use of alcohol or drugs requires coping skills that many people in society -- including even non-addicts -- do not possess (Weinberg, 1973). Respondents identified three main tools which allowed them to maintain sobriety in the face of sometimes overwhelming challenges. Recovery oriented activities are the first such tool. They consist of techniques such as calling sober friends, meditation, reading recovery literature, and attending self-help groups, all of which serve to support an on-going, overarching commitment to recovery and also to buffer the effects of stress when challenges arose. Many respondents indicated that conscious participation in specific activities fostered an "attitude of gratitude". Such activities offered opportunities for meaningful reflection. Finally, steps to carve out a sober niche in an often drug-infested physical environment, and to safeguard themselves and their families from any non-sober social or familial influence constituted a behavioral component employed by virtually all respondents to ensure sobriety.

A) Activities

Every respondent reported spending time each day using an A.A. " tool " to maintain sobriety and to meet challenges. Some part of each day included either a prayer, a meeting, a telephone call to another sober friend, or reading recovery-spiritual literature. Time spent in these activities varied, depending on respondents' responsibilities and emotional states. Some attended self-help groups every day, while others attended once a week. However, most reported daily contact with a recovering peer. In times of stress, participation in these activities increased.

I call friends and go to A.A. everyday. I use my tools. There have been times I wanted to get high but I had to know the consequences. I had to deal with myself. You got to be real with yourself and accept yourself. (PB15)

My disease kicks up on me every other day. I want to use but I do not. I just pick up the phone and call someone and tell them my disease is acting up. I talk and make meetings. I call everybody. I have a lot of friends. Sometimes I call that one, talk with her for two hours, then I call that one with the same problem then I call the next one, talk about the same thing for two hours. I get depressed, I call. That is the purpose of the call so I do not pick -up. (AB1)

I keep busy. I use my time constructively. I take it seriously and I am committed to the tools and the information I got at CR .... I got HALT (an A.A. acronym meaning do not get hungry, angry, lonely or tired). I made a choice... to follow the program and they tell you to pick up the phone and talk about it . I did and I do. I have a sponsor and my sober friends. I call them. I try to go to NA twice a week but I am down to one a week....I read my recovery and other spiritual literature. I am very busy.(UC17)

I cope by bitching. I call my friends when in the past I would have used. I have had $800 phone bills. But it is OK. I rather spend my money on reaching out than blowing it on drugs. I am a talker, I go to meetings, I make meeting three times a week. I talk every day to my sponsor. I keep away from negative people and stick with positive people... I say the serenity prayer. (YB20)

B) Attitudes

Most respondents described the importance of keeping a positive attitude despite

challenges or stress. An ingredient in keeping a positive attitude included being consciously grateful to be alive and sober, despite all odds.

Respondents often invoked the A.A. phrase "keeping it green" to remind themselves of the importance of not taking their recovery for granted, it is in this attitude where many respondents were able to find the payoffs in maintaining an alcohol and drug free life.

This phrase was often evoked as a response to seeing peers relapse i.e."they keep it green for me." For all respondents, prayer was a tool used to give thanks for their sobriety and to assist them in keeping a positive attitude.

A couple of peers fell big time, when I see them it keeps it green for me ...it is a mess. I say the serenity prayer at least 50 times a day. I pray every day. My strongest supports are my peers that are clean because we get together, have picnics, dinners, get the kids together . We all talk all the time. We are together, it is good thing, it keeps our attitude in check.(GB7)

I got a second chance at life... four times I could have been gone. I have a relationship with God. I am truly grateful. He has not let me down.... I want this (sobriety). I made a decision. I am staying clean and sober and I am not going back there. There were four sober peers that came to this building and two are out there now. They keep it green for me just by seeing them. Oh God what messes. All that we went through and how far we came, just seeing they are back there again. I believe if you do not pick up you can not get high... I pray everyday.(FB6)

I meditate a lot. I pray for peace and calm because I get excited. I do not let the disease in my head and I keep gratitude in my head. I have come this far.(ZB18)

A number of respondents indicated that if they were to ever use alcohol and drugs again, it would result in their death. Their belief system saw death as the ultimate consequence for using again. They did not see how they would ever be able to resume a

sober life, given the pains they had suffered and the efforts they had made to achieve the gains in their recovery process.

I believe if I pick up the stem(crack) I will die. I could not get sober again. I am not perfect, but I believe if you do not pick up you will not get high. I believe in God and the better my attitude, the more God helps.(YB20)

I would blow my head off if I smoked (crack) now. My life. I got my own life and I love it. If I were to get high, there would be no coming back. I would die. Really that would be it.(JB10)

If I use again, the bottom line is I will lose my life, my kids, it would destroy my daughter. I saw death many times I could of gotten killed for the things I did. I stuck -up a lot of people-drug dealers. I go to meetings everyday. I pray every morning. I have a higher power I call Jesus Christ. I know Jesus Crist has a hand in my life.
(XB19)

I have done things to make people put a gun to my head, stealing shit... I look back on that a lot and I know I have a Higher Power because only He knows when it's your time...I think half the shit I did, I can not believe I did. I am lucky to get out. If, God forbid, I went back out there, I would not come back. I know that I did so much dirt when I was out there. I know our Higher Power never gives up on us, but I feel I would not make it back. (KB11)

C) Setting Limits: Creating and Maintaining a Safe Haven

Many respondents had to set limits with family members, neighbors, friends, and peers who relapsed, forbidding them access to their homes, and sometimes refusing to socialize with them, to maintain the safety of their apartment. Respondents described the need to remain detached from neighbors, unless absolutely sure that they, too, were sober. Eighteen (90%) respondents described the accessibility of drugs in their immediate environment. Some had to walk through "fogs" of smoke upon entering their building. Many respondents were forced to return to drug-infested neighborhoods due to the non-

availability of low-cost housing elsewhere. Sometimes this proximity to rampant drug use was a source of temptation and risk for respondents. Many carved out their safe and sober niches in the middle of violence and chaos. Some did not let their young children outside. These abominable housing circumstances point out further the need for not only low-cost, safe housing, but also for aftercare services.

> This is the #1 dope block in the city. I know where to get it and if I were to stand out there, everyone would want to give it to me. I do not hang out on this block at all. I do not associate. I come here and I go. They kill a lot of people here...it is a mess. I tell people they can not stay here. A lot of my peers try to come here. Q— leaves treatment and wanted to stay here. I told her she was using .. it hurt to tell her no, but I could not have the shit here with my kids. Come to find out in the next building she got raped and cut in the face. They took her daughter away she was a mess. But I saw her recently she was clean and sober ...good, fat , and pregnant. (MB13)

> It is so noisy, radios, shootings-it is a mess. I do not let my kids go outside. I take them away from here we come and we go. ... The building is not safe... The neighborhood is drug infested... People, friends do not come here. My friends ask "how do you do it?" It keeps it real for me, but for the grace of God go I. My son, he got locked up a few times he is mad, too upset I had to put him out. He cannot live here all high and wanting to smoke weed... I called the police to have my son put out. (LB12)

> It is a pretty good neighborhood. I do not deal with my neighbors, that is one thing I will not do that. It is one of those things.. you start to get to know everyone in the building and hanging out and getting involved in shit. This time I am different. I mean I am nice and polite and I will say" good morning" but that is it. Right across the street there was a spot I used to stick my head out and watch. I did start to dream about it. One day I went to the spot and asked the girl what they had. She said "coke, crack everything. I thought, wow I do not have to give anyone urine. I went back to my apartment and looked out the window and thought about that feeling of getting high, that urgency, that feeling I could feel it for real and you know what ? I felt like I wanted more and more. I was a greedy addict, it dawned on me if I go and spend $20 and then I will spend my whole $200. Fuck that, I closed my window. I felt the high, the urgency, wanting more the need for more.... Now when I feel depressed, I put some music on and dance, and push it away or I grab the kids and say "come on, we are going to the park."(GB7)

> I just moved. I love my apartment. I was able to break the lease because the

ceiling fell in and the bathroom did not work.... I do not know the neighbors and I do not want to know them. I say good night and good morning. There is a cop living next door to me and that is good. That is all I know. I want to keep it like that. ... I keep to myself...I do not have sugar, flour , water, nothing. Do not knock on my door, not even for a cigarettes... (AB1)

Drugs- I do not know where it's at but ain't it in every building? I see people smoking reefer in front of the building, maybe they are getting it in the building I do not know. The building's pretty safe... there are a lot of girls in recovery too, the girl next door and the one below me. We exchange things, flower and eggs. The police come quickly. The other girl next door was getting beat by her boyfriend and the police, seven of them, were here in one minute. .. I learned how to say no. My sister, some of the girls who relapse, they want to stay. I do not let them stay. At first it bothered me but than I thought it is saving my life. I am sorry but I have to say no. They can come, eat and leave. (TC16)

SECTION SIX

RESPONDENTS' REFLECTIONS

A) Accomplishments

Each participant had accomplished many things during and after her treatment for addiction. Every participant maintained a lease in their name. Eighteen (90%) had been re-united with all their children. Another respondent was in the process of having her two children returned to her from foster-care. Eighteen (90%) of the respondents were either working or attending college and of these five were both working and attending college. Many took great pride in the fact that they were taking care of their family business, and attending to parent-child meetings, paying bills, doctor appointments, college and work, etc. Each of the respondents noted however, that the greatest accomplishment was and continues to be not picking up a drink of alcohol or a drug.

Life for many respondents was not necessarily easy, setting limits, dealing with

life's pressures with little material resources as noted remained challenging. Nevertheless, because of the gratitude they feel, even while coping with their challenges, life has its profound joys.

There was a time I did not care for myself. I do not know if it was true before I was burnt, but I hated myself. Now I have come to accept myself. I do not see the scars I see me. The people in my life, everything, my kids, I love ... I know I am loved and I love me... My desire is to stay clean.. and I am very grateful. (BB2)

I can do this (keep sober). I am doing it . I am a strong determined black women. I am going to keep doing it . Too many things I want in life. I have people who love and care for me. I care for me. I feel things I never thought I would. I like it.(GB7)

I am getting my AAS(Applied Science) degree and going to college. I am so proud of myself. I never thought I would do it but I am. I have a lot of love in my life my friends, peers, kids and me. I pray and I stay connected. (HB8)

I am accomplishing one thing now - staying clean and sober- I took my GED and did not pass. It was a hurting feeling. I was off by two to three points. I am going to take it again... You got to stay away from people, places and things. You have to stay away from negativity. Make your meetings, get a lot of numbers and stay in contact with your peers, your family... Being positive... I cry sometimes because I cannot believe what good friends I have. Can you believe that? (FB6)

As might be expected, respondents had definite opinions of what was involved in recovery, and they were very vocal about their suggestions. For virtually all, the bottom line was to not use alcohol and drugs, regardless of any feelings or circumstances. This was accomplished by using practical tools, consisting of attending self-help meetings, calling friends, being honest, using the slogans of self-help groups such as HALT (do not get too hungry, angry, lonely or tired), and avoiding people, places and things that trigger the desire to use substances. When the researcher asked respondents what other women

should know about the recovery process, they responded;

It is not easy... Got to have tools in your back pocket and know which ones to pull out when the time comes. The pressures are going to be there, if it is not going wanting to get high, it will be a phone bill. If its not that, it will be something, and it could be the simplest thing that triggers you... I know I have been successful because I know me. I got real with myself. You got to be real with yourself. You got to accept yourself. (PB15)

Life on life's terms is not as easy as you may think. You make it what you want. Living on life's terms we are talking responsibility, paying the bills, volunteering at the kids schools, getting the kids to and in bed by 9:00 P.M. Dealing with family issues, relationships, no matter what happens the relationship goes, the family don't talk to you no more, whether the kids go and use drugs, you got to stay connected...You need to strap in and prepare yourself, this is the never ending journey and no matter what you I have to make meetings and keep that up front... I have such good friends, people who love me when I don't love myself. (XB 19)

It gets better by sticking it out and not picking-up. Have faith in something. You got to have someone to call, when those kids are getting on your nerves you got to pick up the phone and call. For me, I have to go to meetings. You have to stay busy. You cannot sit in your head for a minute, You can only rest when you're tired, When you're not tired, you got to get up and do something, volunteer, go to a meeting.(LB12)

You are basically trying to get your life together and things happen, things come up. I had to get back in touch with myself being who you are, a mother, being responsible dealing with work. Having things in your own name . You do not have to use your kids names or someone else's name because you did not pay the bill... Stay focused on sobriety, keep in touch with peers that maintain sobriety. Do the best and try to survive the best way you can . Always feel there is someone you can talk to and if there is ever a problem, that is where the rooms come in (self-help meetings). That is important, to have friends who tell you the truth. I have those relations today even at work and at school. (KB11)

Remaining sober has yielded many unimaginable benefits. One participant sums it up:

I love life too much... In the last 4 years I have accomplished more than in my lifetime. I am in college. I have my kids, my sister and her boys. I am responsible. I am a role model. I weighed the pro's and con's and not using is common sense. I am not giving this up. (KB11)

CHAPTER 5

SUMMARY, IMPLICATIONS and RECOMMENDATIONS

Introduction

This chapter begins with a summary of the study and its findings. This is followed by a discussion of the meaning and implications of the findings for practitioners in the field of addiction. The last section of the chapter offers recommendations for further research.

Summary of the Study

The primary purpose of this study was to explore the factors which have contributed to the recovery of a sample of addicted, homeless women with children. The study focused on the personal characteristics, relationships, and environmental factors which, from the clients' perspective, contributed to their successful outcomes. Both quantitative and qualitative methods were utilized to implement the study.

This sample was selected from one residential treatment program in the south Bronx, Casa Rita, operated by Women In Need, Inc. This program was chosen because it had a treatment model designed specifically to meet the needs of addicted homeless women with children. There were also preliminary indications that the program had effective treatment services to homeless women with children as measured by the percentage of client completion of the program and federal and state agency recognition. This program was an exemplary program and fit the study's design to focus and examine

successful cases. Because of the unique characteristics of the population, and this unique treatment model, generalization of the findings are limited. These findings cannot be widely generalized due to the exploratory nature of this study and the limited body of knowledge of formerly homeless women with children in recovery from addictions. Furthermore, purposeful selection of successful cases, a methodology dictated by the focus on factors surrounding success, further limits the application to generalize the findings. Nevertheless, it is possible to identify significant themes which merit further investigation, and to discuss implications for policy and programs for this population.

The quantitative method provided descriptive data and identified the significant variables related to program completion. Building upon this analysis, the qualitative methodology captured themes critical to program completion in the voice of the clients. The final report incorporates two theoretical perspectives, a systems perspective and a "relational" perspective of the population. As noted methodology was designed to focus on successful respondents.

This study fills at least partially a gap in the literature regarding the needs of addicted, homeless women. The data speaks to the effectiveness of this particular treatment program, and documents that, indeed, effectively meeting the treatment needs of this population is possible. Moreover, this study documents the motivation required by respondents to implement the recovery process in their post-treatment daily lives.

Summary of Findings

There are many notable features of this study: the focus on success, the combination of qualitative and quantitative findings, but the most important aspect of this study is the population itself. These respondents -- homeless, drug-addicted mothers, women of minority races and cultures-- are among the most victimized and marginalized groups (Smith et al., 1993). Addicted women and mothers, they have suffered from inadequate parenting, inadequate and inferior education, poverty, histories of abuse, crime and trauma (Reed, 1991; Miller, Downs & Gondoli, 1987; Daghestani, 1988). In many respects, it is surprising that these women have survived at all. Indeed, many others were undoubtedly lost along the way, falling victim to crime, AIDS, relapse and other factors (Rosenbaum, 1997).

Prior to a full discussion of the findings of this study, I would like to bring attention to the social, economic, and political factors of the 1980's which had a significant effect on the lived experiences of these women. During the 1980's, when these women were actively using drugs, two major shifts, one societal and the other political, were occurring. First, the number of female-headed households entering the ranks of homelessness increased dramatically, in part due to the loss of low-income housing stock and the higher- than- average unemployment rate for many minority groups (Nunez, 1995; McChesney, 1995; Hopper, Susser, & Conover, 1985). Second, the smoke-able form of cocaine, "crack," reached epidemic proportions at this time, affecting women as well as men (Kaestner, Frank, Marel, & Schmeidler, 1986). In fact, never before in the history of alcoholism and drug addiction have women been held responsible

for many of societal ills and actively prosecuted for their drug addiction (Rosenbaum, 1997). This combination of factors disproportionately impacted poor women of color (Clayton, Voss, Robbins & Skinner, 1985).

Societal responses, as discussed in earlier chapters, were harsh and punitive. For example, in a few states there were popular initiatives to arrest pregnant, drug-addicted women for the murder of their unborn baby, despite the fact that no death had occurred (Paltrow, 1992). Welfare policies further punished drug-addicted women by excluding them from eligibility (Siegel, 1991; Chavkin, 1991). Even more stigmatizing than being a welfare recipient is being a drug-addicted woman who, although needy, is ineligible to receive welfare because of her disability (Murphy & Rosenbaum, 1999). These proposals only added to further stigmatize and marginalize this already disenfranchised population (Paltrow, 1992).

Such policy response culminated in the passage of the 1986 Anti-Drug Abuse Act, which established mandatory minimum sentences. Following the passage of that law, drug control legislation was introduced during every Congressional-election year in the 1980's. Some of these proposals included mandatory life-sentences and denial of federal Welfare grants upon conviction of any drug crime, even a misdemeanor (Schosser, 1997). In 1996, a limited version of these bills was incorporated into the federal Welfare bill prohibiting Welfare benefits to people convicted of a drug felony. Two respondents in this study were convicted of a drug felony; they were both fired from government jobs that paid $13.00 an hour with benefits. They were fired for lying on their applications about their criminal record. Consequently, their wages were dramatically reduced. One

currently works at Kmart for $6.50 an hour, and the other has returned to school. Unfortunately, like many convicted under this act, they will always be burdened and limited by this conviction, without regard to how productive they are or how long they are drug-free.

Continuous media images depicted crack-addicted women as savage monsters, uncaring for their children (Reinarman & Levine, 1989; Morgan & Zimmer, 1997; Humphries, 1999). Often crack use was regarded as the sole reason for child abuse and negligence (Hinds, 1990). It was commonly held that drug-addicted women with children needed to be punished, and the children removed from the home (Coltoff, 1996). The policy of mandating newborn babies of addicted women to remain in the hospital (the "boarder baby" phenomenon) incorporated some of these punitive elements. The political discourse did not extend to the root causes and needs of this population, but rather focused on the need for more social control (Rosennbaum,1997). One respondent aptly states:

> I read the newspapers. I know how they talk about us. They want to take my kids and lock me up. What I really and my kids needed was help. I felt, feel guilty enough, I am not an animal. (YB20)

Reminiscent of the first epidemic of cocaine use at the turn of the century when "Negro cocaine fiends" were "terrorizing" the South, this epidemic of crack-cocaine also triggered excessive responses; police purchase of larger caliber guns, national controls, and punitive measures (Musto, 1997). For the African-American, there was a false link between cocaine and violent crime. This link between the feared minority and a given drug has its roots in history and racism (Musto, 1990). The fear of the other and images

of African-American, female, homeless crack addicts perhaps are embedded in this link between race and crack and crack and the worst sort of violence, i.e., child killers (Hinds, 1990; Humphries, 1999).

In many ways-- psychologically, racially, socially, economically, and politically-- these women were under attack from all fronts, the media, the courts, the public and most dramatically, their own painful lives.

Life Before Casa Rita

This population had lived a very traumatic and deprived life. All had been exposed to alcohol and drugs since early childhood. Based on the quantitative sample, sixty two percent (62%), approximately two-thirds of the sample, had a father who had a problem with alcohol or drugs. Thirty-one percent (31%) had a mother who had a problem with alcohol or drugs. Ninety percent (90%) of the respondents described using either alcohol or drugs prior to their fourteenth birthday. The average number of years of school completed was 10.6 years. Reports of physical abuse (68%) and sexual abuse (45%) were common among this sample. These variables usually preceded addiction and clearly demonstrate both the lack of opportunity for these women and the serious problems they had to confront.

Many studies (Fraser, 1996; Loeber, Stouthamer, Kammen & Farrington, 1991; Maas, 1986) describe the negative impact of poor social and economic conditions on normal child development. Children reared in poverty lack opportunities and role models

for successful social participation, and are seriously disadvantaged in developing skills which promote sucess in school, work, and other life settings (Fraser, 1996). The samples from both the quantitative and qualitative study has indeed been burdened not only by poverty, but also by having been themselves children of substance abusers (Brisbane, 1985; Wegscheider, 1981). The psychological consequences of being raised by alcoholic and/or drug addicted parents have been extensively documented. These problems can include learning disabilities, failure to develop trust, and a whole series of psychological and emotional vulnerabilities, including excessive feelings of guilt and shame. An entire "laundry list" of symptoms describing the difficulties of adult children of addicted families has been developed in the recent proliferation of self-help literature (Bradshaw, 1996; Blume,1991; Larken, 1997). Many of these respondents are prototypical in illustrating the consequences of growing up in poverty and having parents with addiction problems. They experienced dropping out of school, teen pregnancy, poly-drug use and criminal behavior. The following discussion is based on the qualitative sample.

Pregnancy and Childbirth

A striking finding is that ninety percent (90%) of the respondents had their initial realization of having a drug problem only during a pregnancy or after giving birth. It took an event of this magnitude to penetrate the denial. Still, many did not seek treatment at that point. However, as suggested in the literature, childbearing women experienced

important changes in their relationships with others (Ballou, 1978; Finkelstein, 1990). This finding suggests that motherhood also changed the relationship women have to their addiction. Even when respondents continued to use substances, they experienced an awareness that the abuse was a problem. For some women, it was the feeling of love for their infant, and for others, it was their erratic behavior with a baby that fostered reflection about substance abuse. Some sought treatment, and some did not. For this latter group, children were often removed by authorities for negligence and abuse. Whether treatment was immediately sought or not, most respondents experienced a change in their perception and came to view their addiction as a problem having a consequence for pregnancy and childbirth. The women themselves often refer to the baby whose arrival triggered reflection and motivation for treatment as "miracle babies." This supports evidence that drug abusers are just as likely to change for positive reasons as for negative ones (Barber, 1995).

Something was Different This Time: Significant Variables Associated with Program Completion

Respondents in the qualitative sample described events that contributed to "hitting a bottom," that is, the point at which they felt they could go no lower. This research has shown that hitting a bottom is a cumulative and composite experience that involves multiple hardships. Many of these experiences-- being raped, robbed, losing apartments, losing custody of their children-- had occurred while respondents lived on the streets or

were doubled-up with family members or friends.

The quantitative findings indicated the variables most significantly associated with program completion are associated with the phenomenon of "hitting bottom." One such variable is homelessness, being homeless for an extended period of time was positively associated with program completion. The findings suggest that the experience of prolonged homelessness may have motivated these respondents to remain in a treatment program which ensured an affordable apartment upon completion. Arguably, housing was a co-factor to addiction recovery in motivating respondents to seek treatment.

In addition, extended periods of homelessness also represented multiple apartments secured and then lost again, the vulnerability of moving from one shelter to another, one crack house to another. These circumstances contributed to an awareness that both their addiction and homelessness, was a problem. In sharp contrast to the implication of these findings is in policy makers who insist that all that is needed for the homeless population is housing. Such premise may have validity for a homeless sub-populations unaffected by addiction or other special needs.

Every respondent in the qualitative sample identified an experience or event that provided motivation to beat the addiction. This motivation was often described as offering a sharp contrast to "other times"they attempted to stop. Respondents described being "sick and tired of being sick and tired." Such a moment was often joined to having a chance and opportunity to obtain residential treatment with their children. Many did not have much to lose, having already lost their homes, children, and self-esteem. Often

someone managed to get through to them a close family member, a counselor, or a child, and provided some part of the motivation to seek or take advantage of recovery opportunities. For many respondents, the repetition of having "been down that road before," and the anticipation of the all too familiar pains and humiliations was motivating. Seeing their behavior from a different perspective, as if looking in a mirror for the first time, resulted in the possibility of a fresh start. Such a moment is often described by members of Alcoholic Anonymous (A.A.) as a "spiritual experience" (A.A., 1953). It is possible this recognition, insight or spiritual experience contributed to the reasons respondents sought help, and may also explain their gratitude. They knew that they could have just as easily missed that moment.

Systems theory posits that the change process often includes a chaotic period, which can entail a certain disequilibrium. Sudden changes in thinking and behaviors, and distressing emotions are often a necessary part of the change process. Moreover, in the change process chaos often affords more flexibility, and thus more opportunity for change (Warren, Franklin, Streeter, 1998). It is perhaps during this time of disequilibrium for substance abusers that the transformative experience of recovery, provides motivation and program completion is most likely to occur.

Another variable found to have a trend toward significance associated with program completion was prior multiple drug treatment. Some studies (Roberts & Nishimoto, 1996; Stark, 1992) have found that prior treatment was unrelated to program completion, and rationalized that previous drug treatment reflects a more severe and more resistant drug problem. In an ethnographic study, past treatment involving detoxification

was rationalized as supporting and enabling the lifestyle of an addict. More specifically these authors argued that detoxification programs served to provide a respite from the rigors of street life and a way for users to avoid drug sellers to whom they owed money, without having to make any real effort to achieve or maintain a sober life (Johnson & Dunlap, 1996).

Conversely other research (Means et al., 1989) suggests that prior drug treatment may contribute to program completion. The findings from both the qualitative and quantitative samples of this study support such contention. Previous drug treatment experiences may promote "kinds of learning" that increase the probability of program completion. For example, women who have been exposed to group support and individual counseling may have learned how to use the group for their stated needs. Alternatively there may be a learning curve for those who are new to treatment as they access the help and support they need. In addition, women may process prior treatment experiences followed by relapse differently from men. Both might see prior treatment and relapse as "failures," but arguably men may attribute failure externally to the program, become hopeless about eventual success, and remain unwilling to try again. Women, on the other hand, are more likely to internalize or "own" the failure, an attribution style which may lead to a willingness to try again (Gilligan, 1982).

Finkelstein (1990) points out that making meaningful changes in the cognition, attitudes and motivation of a substance abuser is such a daunting task that often repeated and sustained efforts over time are necessary. From this point of view, past treatment experiences reflect respondents' continued motivation to overcome their addiction

problem. This finding which suggests that recovery occurs for many through cumulative program experiences may bring hope to both addicts and addiction treatment providers who often view prior treatment experience(s) as a failure.

Respondents described how prior treatment experiences had "broken down". In this regard, the Casa Rita treatment modality, carefully designed to address the needs of a disenfranchised female population, made a critical difference in respondents' experience. In some cases, respondents described their past treatment as being harsh and punitive. A few had been through residential treatment programs which used traditional techniques of confrontation and reward systems for compliance. Given the evidence that traditional drug-treatment programs fail to meet the needs of women (Nelson-Zlupko et al., 1995), it is important to recognize that the supportive and safe environment of this program -- where confrontation and rewards were not used -- may have provided at least some of the ingredients necessary to effectuate a meaningful change. One study (Walker, Eric, Pivnick and Drucker, 1991) notes that success with women is based on a program philosophy "that focuses on the strengths of each individual and uses her experiences, both past and present, as learning tools rather than as sources of grief and shame." The focus of the Casa Rita program indeed draws, the positive elements of the client's history and personality, and the use of life experiences as learning tools.

Treatment at Casa Rita

The high program completion rate of the program of the quantitative sample

subjects, nearly 65% or approximately two-thirds, is exceptional compared to other studies (Smith et al.,1993; McLellan et al., 1993). In other studies of programs designed for women (Williams and Robertson, 1991), the best retention rate for cocaine (crack) users was fifty percent, and for homeless women with children fifteen percent (Smith, North, and Fox, 1995). The high program completion rate is even more remarkable given the population served. As previously discussed, this population consists of homeless, substance-abusing women of color who come from substance-abusing and dysfunctional families. Most had been sexually and/or physically abused both as children and as adults, and the primary caretakers of children. In addition, they have housing and legal problems, limited formal education and few vocational skills. Given this multi-problem profile, these women are among the most difficult to engage and maintain in addiction treatment. Clearly, the program made a difference in participants' choice to remain sober and free of drugs.

The following sections and discussions are based on the interviews from the qualitative sample. The next section will focus on the most important aspects of treatment, as described by respondents.

Children

Similar to other study results (Scumacher, Siegal, Socol, Harkless & Freeman, 1996; Wobie, Eyler, Conlon, Clarke & Behnke, 1997), this study's findings indicate that having children in the treatment program provided specific kinds of motivation for

respondents. The children of these women provided them with great joys and challenges during and after treatment. Interestingly, having their children with them in treatment also seemed to help respondents adress feelings of guilt and shame. The clients' children too were in recovery, and they also reaped the benefits of a treatment program. The women came to realize the work that lay ahead to re-build relationships, and secured the professional help for their children's special needs (speech, language, and emotional problems). The fact that they could do something for their children also may have contributed to their successful completion of program.

Attitudes of Treatment Providers

This study's qualitative findings has clearly shown that the two program/professional and program attitudes required to successfully engage with clients 1) not to pathologize and 2) not to blame participants. Respondents repeatedly described that they were respected as women and treated well. Program participants were not pathologized as "sick addicts," but rather were viewed as women, human beings, with their pains and aspirations. Consequently, participants were able to engage in the treatment process. Their addiction was viewed as a disease and an attempt to cope with other life stressors. At no point in the treatment process were respondents blamed for their homelessness or addiction.

The program/professional explaining that a large part of the horrendous present circumstances can be traced to the addiction serves several important functions. First, it

explains her past behavior in a way that gives her hope for the future. Second, it helps cope with her guilt, anxiety, remorse and confusion. Third, it provides her with a specific behavior (staying sober) that will change her life in a desired direction (Wallace, 1978).

The program philosophy at Casa Rita promotes the idea that everyone is responsible for their own behavior. In a delicate balance, counselors were able to demonstrate respect and a non-judgmental attitude that did not pathologize the clients, while nonetheless holding them accountable for their behaviors. Rosenthal (1986) found that the level of expectation and tone of voice determine clients' behavior. In his seminal study with school children, teachers who were told they had exceptional students raised the level of expectation, and all students responded without regard to their prior capacity. In later works, Koss and Rosenthal (1995) found that certain non-verbal behaviors such as smiling, nodding, high levels of eye contact, and forward trunk lean influenced a client's positive behavior change. Clearly, when respect, expectation and a non-judgmental approach are communicated, a client's behavior can change.

Counselors were consistently described as empathetic, understanding, and knowledgeable about addiction. Respondents reported that the message received in treatment was that they were valuable human beings with addictions and additionally, that they were responsible for their own behavior.

Strikingly, in making decisions, the counselors took their cues from the needs of the respondents as well as from the program's philosophy and guidelines. This has been demonstrated by the 1) open-ended length of individual counseling sessions and 2) the counselors' decision making processes and actions which involved respondents and their

children, as discussed below.

1) Individual Counseling Sessions

The importance of individual counseling was highlighted by most clients. The program scheduled all individuals once or more per week, based on the need of the client. Respondents reported that counselors provided open-ended individual sessions of unlimited duration. Respondents also experienced counselors as being available 24 hours, seven days a week. These flexible open-ended sessions were reported as helpful by respondents. Although counseling sessions of unlimited duration and counselor availability at all hours were not prescribed by the program guidelines, the mere existence of such a structure was helpful and provided hope to respondents.

There is little scientific evidence to support the superiority of one treatment modality over another, for example, individual therapy versus group therapy (Vannicelli, 1984). Nevertheless and consistent with the literature (Wilsnack & Wilsnack, 1992), many women prefer individual counseling. This study reinforces these findings and indicates the great importance of the individual counselor to the respondents' recovery.

2) Counselors' Decisions

The basis of all modalities of drug treatment is that addicts are responsible for their own behavior. Thus, it is inappropriate to protect them from the consequences of

their own decisions (Barber, 1995). For the most part, counselors adhered to this tenet and did not minimize or protect respondents from the consequences of their addiction. However, on some occasions, counselors did contradict this fundamental premise. Specifically, on occasion a counselor would postpone reporting a "dirty " urine until after an imminent child custody hearing. For example, one counselor told a respondent, "I am going to make believe I did not open the report and will open it tomorrow (the day after court)." Had the report been submitted prior to the hearing, this respondent would have immediately lost custody of her children, which would have resulted in her transfer out of the program to a single woman's shelter.

The counselors made these decisions based on their relationship with the client and not based on program policy or professional ethics. Despite the risks in specific counselors' decisions, trust was deepened between the counselor and respondent when risks were taken in behalf of clients. Respondents appreciated the counselor giving them another chance to demonstrate their desire to remain in treatment. The counselors' decisions may have provided yet another motivation for these clients to complete the program. However, the counselors' action does raise ethical concerns.

Jordan (1991) describes the therapeutic relationship between women as a mutually enhancing experience, in which the counselor has to stay connected to the client to maintain empathy, a key to change. Decision-making processes are determined by both the counselor and client. A critical consideration is appropriate consequence for specific behavior. Basically, it is within the context of the relationship, and not by the strict enforcement of rules, that an empathetic relationship is established. In part, the decision

these counselors made was based on the severe consequences to the respondent of having her children removed. Understanding that children were a strong motivating factor to recovery, counselors decision-making emphasized maintaining the family's structure.

Gilligan (1982) describes different perspectives in moral development for women versus men having these differences are attributed to the experience of the self. More specifically these differences have been portrayed as a" justice perspective" versus a "care perspective." Although both boys and girls understand the differences between justice and caring in making moral decisions, boys overwhelmingly prefer making choices based on justice while girls prefer to base theirs on care. For these counselors, what may be viewed as inconsistency and a disregard of professional ethics, might otherwise be seen as viewing relationship with the respondent as involving conflicting responsibilities, i.e., enforcing the consequences of a relapse in a child-welfare case (justice perspective) versus mitigating such consequences to foster a therapeutic relationship and maintain the family unit (caring perspective.)

Counselors who emphasize in their decision-making the nature of the therapeutic relationship, the level of client motivation, and the potential consequences of decisions often foster a healing and therapeutic relationship (Jordan, 1992). Indeed, it is probable that delaying a dirty urine report under the circumstances promoted respondents' completion of treatment.

The treatment program was designed so that each family had their own room and key. This policy was unusual in residential programs. In most treatment programs, residents have to earn their own room and attain a certain period of sobriety to regain

custody of their children. At Casa Rita, each woman's room was her right. This sense of privacy and space helped women feel that they were trusted. Unlike other residential treatment programs, respondents were able to attend to activities of daily living in the community. The physical design of the facility may have reinforced an attitude of respect and trust, creating a "safe space" which allows for personal disclosure.

The ability to disclose painful memories and secrets was a very empowering act for residents. It was important that the experiences of these women be validated and not denied in order for the treatment process to work. Such validation was especially important given the societal stigma and experience of being dismissed as worthless. Creating an emotionally safe and supportive environment allows women in treatment to address issues of sexual, physical, and emotional abuse at the rate and intensity appropriate for each individual (Nelson-Zlupko et al., 1995). Thus, a program atmosphere of healing and taking care of children was transformed into a lifetime of recovery for many. In conclusion, the important ingredients of the residential treatment program included; residents having their children, treatment providers having a non-judgmental attitude, an empathic therapeutic relationship which gives critical consideration to appropriate consequences for specific behaviors, and a physical environment which supports safety and respect.

The following discussion will focus on the elements required to sustain sobriety after treatment. This discussion is structured by six categories; keeping sober and clean, changed thinking, continued recovery-relationships, obstacles to remaining drug-free, individual challenges, romantic challenges, and environmental challenges.

Post- Treatment

Keeping Sober and Clean

A most compelling finding is the degree of diligence and hard work it takes for respondents to remain clean and sober. The recovering person must strive for superior, not average, emotional adjustment, because in our society the "average person" uses alcohol and other drugs rather than developing and relying on internal coping mechanisms (Weinberg, 1973). Each respondent described having to be aware of her emotional states by leading a life of reflection and daily activities structured around staying sober. Many respondents described that their daily life included: prayer and meditation, keeping connected with other sober friends, rebuilding and strengthening relationships with children and romantic partners, attending to work and school, paying bills, cooking, cleaning and other activities of daily living. Although these activities may be mundane for most people, for these respondents, they are part of the extraordinary recovery process that includes continuous self reflection. For example, one respondent described going to the store and buying coffee and cigarettes.

> Just yesterday, I got excited because the man did not want to sell me a pack of cigarettes because I was on the outside of the line... I got so angry I snatched the money up and threw the coffee in front of the man's store. What was that about? I had to look at myself. I was not spiritually connected to anyone. I was nervous about the job interview. I could have just got in the back of the line, but no. I am going to fix you. I was going to walk 5 blocks away to buy cigarettes at another store. I am still mad and I have no coffee and had to pay more. Who is all that hurting? I have to get on that phone, first I pray for peace and calm I get excited.(BJ18)

Every situation, even the most insignificant, becomes a testing ground for

respondents' newfound sober lifestyle. Each victory, however small, is valued by respondents. After paying a bill for example, many respondents felt proud that the bill was in their own name and not in their son's or daughter's. A bill with their name on it represented honesty, integrity and a sense of pride for taking responsibility for daily matters.

Changed Thinking

The significant changes in respondents' thinking represent an important element in maintaining sobriety. They became grateful for having survived. They described praying for more patience and tolerance, as well as feeling gratitude for being sober. Some stated that they prayed throughout the day for patience with their children. Many described being grateful for the responsibility of bills, and a lease. These responsibilities, often viewed as a burden and taken for granted in many peoples' daily lives, are profound joys in some respondents' lives. For many, meeting these responsibilities demonstrated their hard work and integrity, and how far they hade come in their efforts to be productive members of society. This change in thinking, taking responsibility for their actions, and assuming a posture of gratitude, began with the decision not to drink and /or drug, and spread into overtime into other aspects of their lives.

Again, the concept of the non-linear model can help us best appreciate the magnitude of change achieved and the speed of the change. A number of respondents described dramatic changes in their thinking and in their lives. Prior to recovery they

lied, cheated and stole from family, drug dealer boyfriends, put guns to people's heads and did whatever was needed to survive and score drugs. Presently, as little as two years later, their daily lives are different. Daily activities with their children include making breakfast, lunch, dinner, as well as going to school, going to therapy, praying, and reflecting on their daily experiences, talking with friends and family members.

Continued Recovery - Relationships

The relationships and connections that are significant include, first and foremost, those with their children; second, those with sober friends and peers; and third, those with romantic partners. All twenty respondents discussed the importance of relationships with their children. Most discussed praying for patience and tolerance. Adjusting to the role of being a responsible mother took time. Parenting is central to many women's identities and is often a source of much anxiety and guilt. The guilt about parenting is exacerbated if their children have any serious physical, emotional or learning problems (Finkelstein & Derman, 1991). Many respondents coped with their anxieties and worries about their children and their future by participating in daily activities that included talking with other recovering parents, reading spiritual literature and having faith that their children too, have a God/ Higher Power to protect them. Some respondents had to initially spend much of their day post-treatment securing and maintaining educational, physical and mental health needs for their children. For respondents with children who have special needs, it continues to be necessary to spend an inordinate amount of time with specialists

and schools to secure and maintain appropriate resources.

Nevertheless, the joy and pride in their children's accomplishments contributed to daily pleasures. Success in staying free of drugs can depend largely on the life-sustaining connection that a parent has with his or her children (Plasse, 1995). While using, some respondents thought they would never see their children again.

Sober friends and peers were also very important in the on-going recovery of respondents. Every respondent kept in touch with at least one sober friend from the treatment program. Many had sporadic communication with multiple peers who remained sober. Some had up to four close friends from treatment with whom they spent time and shared child-care and family get-together. This source of support was extremely helpful in respondents' maintaining sobriety and "keeping it green".

Some respondents reported attendance at Alcoholics Anonymous or Narcotic Anonymous on a daily basis, a few attended these meetings very sporadically or only when they felt the need. Every respondent knew where and when a meeting was held, and had contact with either a sponsor or another recovering peer.

Most (95%) of the respondents chose romantic partners who were in recovery programs and self-help groups, such as Alcoholics Anonymous or Narcotic Anonymous. The choice to be with other sober partners underscores the importance to recovering women of relating to other recovering people. These connections with romantic partners from self-help groups are based on a mutual understanding of the nature of addiction and contribute to the development of a relationship based on acceptance and mutual care.

Not all relationships were successful. In some situations the relationship ended

when a partner relapsed; other relationships ended due to a lack of commitment. Even after those failed romantic relationships, the respondents were able to accept their pain and disappointment without using alcohol or drugs. Consistent with findings of a study based on the support of male romantic partners during and after treatment, some partners were sober and supportive, while others were uninvolved and provided little support, while a few were actively unsupportive to the woman's choice to remain free of drugs and alcohol (Florentine, 1997).

Obstacles to Remaining Alcohol and Drug Free

Despite the hard work of respondents to achieve and maintain sobriety, success was not guaranteed. All respondents reported to having at least a year or more of continuous sobriety when interviewed. Of the twenty respondents, three had an alcohol relapse for a brief period post-treatment; none of them reported drug-use. Social pressures and interpersonal conflict along with responses to stress and feelings of anxiety, fear, anger, frustration or depression often preceded a relapse into using drugs or alcohol (Peele & Brodsky, 1991). In this qualitative sample, two respondents drank alcohol in response to relationship stress and one in connection with a social celebration. One respondent, on a hot day, after her boyfriend had relapsed with drugs, drank one cold beer and promptly returned to the store and bought a six-pack. The second respondent reported drinking after experiencing anxiety in connection with an initial homosexual experience. The third respondent drank a glass of wine at a wedding.

Two of the respondents who drank alcohol did not continue to drink on a regular basis and one reported drinking periodically on weekends for one year. The latter respondent felt the drinking was related to unresolved issues around sexual abuse and recurrent depression. Another factor in her drinking was social isolation. This respondent lived around the corner from another sober peer for two years post-treatment. The two friends shared baby-sitting and family activities. After the sober friend moved South, this respondent lost the sober support this women had provided for her e.g., arranging barbeques, picnics and daily telephone calls. It is interesting that, despite occasional reports of drinking post-treatment, these women eventually did become totally abstinent, apparently defying the A.A. mandate of the necessity of total and permanent abstinence. Nevertheless, there is no implication in any situation presented that social drinking is a safe practice.

Remaining Sober: Individual Challenges

The process of remaining sober is a personal experience which requires a commitment not to use alcohol or drugs despite feelings, thoughts, and/or circumstances which arise. The ability to sustain this decision through periods of loneliness and emptiness is a prerequisite for continued sobriety (Fogarity, 1997). Feelings of emptiness do not necessarily abate with sobriety, however. Loneliness and depression often occur concurrently, but the qualitative study sample learned that they can survive these states, and even from them. Due to their faith in a God or Higher Power, many are able to trust

that there is a plan for them that is better than what they may envision. In this way, respondents were able to move from merely surviving their addiction, to improving the overall quality of their lives.

In many ways, these respondents' lives are now on a path. Despite feelings of anger and rage being ever present, respondents seek to calm themselves through prayer, meditation and talk with other sober peers. Feelings of gratitude, joy, love and peace are all part of the coping mechanism used to face the fears, hopes, and limitations of their lives.

Challenges in Romantic Relationships

Relationships have proven to be very important to these respondents and romantic relationships provide them with much support as well as challenges. Many respondents described problems with control issues, often leading to the failure of their relationship. These control issues may be exacerbated by the recovery process which involves the acceptance of personal responsibility, and increased independence in decision making (Sandoz, 1991). Many respondents described having been out of control and dependent on the kindness of family, friends and strangers during their active addiction. Now, in recovery, they enjoy new freedoms and want to exercise responsibility by making their own decisions.

For the recovering African-American couple, whether straight or gay, romantic relationships pose challenges, due to the impacts of being poor, dealing with racism,

sexism, and personal recovery. African-American women's ability to adapt, through necessity, to roles traditionally viewed as male, has perpetuated white society's myth of viewing them as a matriarchy (Taha-Cisse, 1991). Historically, this myth was created not to empower African-American women but to further emasculate African-American men (Ladner, 1972). Some of these challenges are embedded in the consequences of racism, i.e., the fact that African-American men have few job prospects, and are over-represented in underpaid jobs. Additionally, welfare allocations and other critical supplements are reduced when a partner or husband is involved. Thus, unlike white middle-class America where marriage produces tax-breaks and other social benefits, poor minorities are penalized for marriages or formalized partnerships (Sidel,1996). For example, one respondent discussed how marrying the father of her children would result in a reduced rental subsidy.

Some respondents attributed the ending of relationships to the inability of their mate to carry their weight, holding onto a job and/or relapsing. Often these partners were unable to contribute sufficiently to allow the women to survive without government assistance. These economic and societal influences also complicate how relationships are negotiated. For example, the lack of availability of affordable housing in New York City may indeed prevent partners from establishing their own residence. Additionally, rental and other forms of assistance are jeopardized when another adult's name is added to the budget or lease. All respondents have a lease in their name and receive rental assistance in one form or another. They may consider that the risks of involving a second adult as too high to give up unilateral control.

Environmental Challenges

A number of respondents made adjustments to living in neighborhoods which did not necessarily support their sober life style. Adjustments included setting limits with neighbors, unless they, too, were recovering from addiction, or were affiliated with a church and did not use drugs. Respondents' sense of "place" was not in their immediate environment, but in the space where they had created sober supports.

Maluccio (1989) states that a person's environment has an influence on their behavior. It is common knowledge in substance abuse treatment that environment is a factor in the availability and use of drugs (Hawkins, 1995). Most respondents lived in poor neighborhoods where drugs were accessible. The neighborhoods were described as providing easy access to drugs, and characterized by high poverty and high crime. Even after treatment, some respondents moved into buildings where they had to walk through a hallway filled with smoke from marijuana and crack. Respondents described having to ignore the building environment, and create their own safer environment in their apartments. The respondents often viewed their apartments as safe, and made a distinction between their building and neighborhood. Many described their building as safe, but only one described her neighborhood as safe. Many spent little time in their neighborhoods. Three respondents described their building becoming safer due to police raids on drug dealers. One respondent described watching through her window the comings and goings in a crack house. In all these situations, respondents did not use drugs and maintained abstinence, despite their surroundings. A few attended N.A. and

A.A. meetings in their neighborhoods, however most went to other meetings outside their immediate neighborhood. Some remained with the support group they had formed during treatment, and others went to support groups near their work or school.

In some cases, respondents' children played with other children in the building. However, communication with these children's parents was limited due to substance - abuse. In some cases it was evident that the respondent was a "protective" factor and a role model for other young children.

CONCLUSIONS

Several conclusions may be drawn based on the findings of this study. These conclusions will be organized around three different phases of the respondents substance abusing experience; prior to treatment, treatment and post treatment.

Prior to Treatment

1. Homeless women, like other women are motivated to stop using drugs by both positive and negative factors.

2. Pregnancy and childbirth are particularly critical times for these women in arriving at a decision to change their relationship to alcohol and drugs.

3. "Bottoming out" facilitates respondent's seeking treatment. However, the "bottom" is a cumulative experience which apparently can be interrupted and short-circuited by

others, including family, service providers, and children.

5. Prior failed attempts at drug treatment are not indicative of a poor prognosis, but rather may indicate a sustained effort at change.

6. Traditional drug treatment that employs punitive approaches fails to meet the needs of these women.

Residential Treatment at Casa Rita

1. Having children in the treatment program motivates homeless women to abstain from substances.

2. A non-judgmental approach and respect are important components of the therapeutic relationship. The attitudes of treatment providers required for success are; not to patholgize and not to blame clients.

3. Important messages necessary for successful treatment are that clients are valuable human-beings with addiction problems and that they are responsible for their own behavior.

4. The client's relationship with her counselor is an important factor in recovery.

5. Decisions regarding provision of timely positive urine reports to child welfare authorities should be influenced by the nature of the therapeutic relationship, the level of client motivation and the potential personal consequences of the decisions, and not simply strict reactive adherence to rules.

6. Having a private space with a key is important to recovery.

7. Because of homeless women's past treatment experiences with racism and sexism, an all- female setting which utilizes a feminist and alternative approach to treatment is significant for success. Additionally, the approach must include an understanding of the complexity which race and power dynamics play in the lives of both practicioners and clients.

8. The respondent's relationships to her peers in treatment provide a significant support system which often continues post-treatment. This support network needs to be nurtured by the agency so that it can be sustained upon clients' reentry to the community.

Post Treatment

1. A high degree of diligence and hard work is essential to remaining sober.

2. A daily life structured around staying sober includes prayer and reflection of daily thoughts, feelings and actions.

3. Important changes in thinking include; viewing personal and family responsibilities with gratitude, praying or using a mantra for developing tolerance and patience with children, when upset or frustrated i.e. not to scream or hit them.

4. Recovering women desire to establish relationships with their children which are different from the way they were themselves raised i.e. having a two way dialogue with children about drugs, feelings, school work, friends, and other concerns impacting their relationship.

5.. Coping requires sharing feelings and experiences with a network of other recovering

friends and family members.

6. As illustrated by the overwhelming number of romantic partners who were recovering from addictions, it is important in establishing intimate relationships that individuals understand that they are involved with someone in a recovery/healing process thus, they have entered a growing relationship and not a stagnant one.

7. Primary sources of support are the twelve-step programs, Narcotic Anonymous and Alcoholic Anonymous.

8. Relapses revolve around social pressures and interpersonal conflict as well as disappointment.

9. Challenges to remaining sober include; dealing with limited incomes, relationships with children and romantic partners, and setting limits with family members and neighbors.

10. Having an apartment with a lease in one's name despite widespread drug availability and danger of the neighborhood is very important.

This study provides evidence that an alternative treatment program is very helpful in the post-treatment success of addicted, homeless women with children. In addition, this study documents the attitudinal and behavioral changes the respondents underwent in their journey and transformation.

IMPLICATIONS and RECOMMENDATIONS

The complexity of treatment considerations for addicted, homeless women with children argues for multiple interventions at all policy levels. Strategies must range from the alternative and culturally relevant approaches which address the personal needs of these women, to community and national policies and interventions which address issues of poverty, homelessness and addiction.

A simple policy or theory can not adequately account for or change the deplorable conditions impacting on the lives of these respondents. An understanding of the complexities of these women's lives require both a macro- and-micro -analysis of the entire society. These macro- issues would need to extend into policy areas that include but are not limited to housing development, job development and childcare. This is a necessary part of the solution to effect change for this population. This study includes only a few theoretical explanations to understand the problem, or to provide a context for amelioration. The implications of this study may further assist treatment programs and the field of addictions as well as social workers, but the study is limited in its ability to recommend macro-policy changes that would be critical in changing the conditions of this population.

The social work profession has played a significant role in treating and advocating for powerless and disenfranchised groups of people (Tripoldi, Fellini, Epstien and Lind, 1977). It has traditionally used and developed a variety of casework, group work and community organizing strategies to effectuate both policy and individual change on

behalf of a variety of populations, including women with addictions and homelessness. The profession's commitment to social change and social justice is a value that must be translated into helping women understand the effects of institutionalized discrimination and oppression, and sorting out the effects of oppression and pathology.

For many women in poverty suffering from addictions, program responses based on an understanding of their situations, or on informed social science theories are absent. Consequently, women tend to continue to underestimate their abilities, blame themselves and suffer from low self-esteem (Finkelstein et al., 1990). This undermines treatment in a variety of ways including but not limited to women dropping out of treatment (Zankowski, 1987). Clearly, overcoming the many barriers to successful intervention with homeless addicted women requires long-term system-level reform that provides genuine options in their lives. The following points and recommendations from the findings of this study may further assist the social work profession to meet the needs of this population.

Social Work Practice Knowledge

1) Knowledge about addiction is crucial to effectuating changes with this population, including an appreciation of the slogans and language used in self-help groups.
2) The addiction process must be viewed as a disease, and behaviorally as a misguided attempt undertaken to alleviate other life stressors, a sort of failed coping mechanism.
3) The application of program rules and regulations needs to be flexible, depending on the

assessment of client's motivations, relationships and consequences of the behavior.

4) Non-judgmental attitude on the part of the social worker is critical to meeting the needs of this population. Social workers must actively critique their own sexist, racist and punitive approaches perpetuated and reinforced in the larger society with regard to substance -abusing women.

5) Central to social work practice is a focus on client's strengthens and possibilities, a focus which is particularly helpful with this population.

6) Respect is paramount for the development of a therapeutic and healing relationship. Respect is exhibited at the level of policy by giving client's privacy, e.g., a room with a key and at a practice level, e.g., by listening and not interrupting them to make a point.

Program Implications for Residential Treatment Programs Serving Homeless Women with Children:

1) A holistic treatment model that addresses all needs, i.e. health, educational, vocational, parenting and mental health of poor women in the context of their addiction is effective .

2) Program philosophy and approaches must consider the economic, cultures and gender factors related to homeless women and their children.

3) Program philosophy should include the view that re-unification with children is not necessarily an earned right and consequence of "good " behavior or adherence to rules of a time line, but rather, a decision based on the desires and needs of each individual women and child. It is important that traditional gender roles (motherhood) be chosen

only when women are ready. It is also important for children to have their needs considered during this process.

4) Provision for child care is essential.

5) Training needs of staff are important to assist them in maintaining a non-judgmental and respectful attitude, as well as maintaining an up to date knowledge of trends and literature on addiction treatment.

6) Each family needs to have the privacy of their own room.

7) It is beyond the scope of drug treatment programs to meet all the needs of this population. Thus, linkages and resources to self-help groups, housing, schools, medical facilities, and other services are crucial.

8) After-care support is an essential process to facilitate the adjustment to drug-free independent living. Especially critical is the coordination with foster care, with the goal, when possible, of reuniting children who were not in residential treatment and preventing future placements.

Policy Implications

1) More funding is necessary for the provision of residential treatment programs for women and women with children.

2) A re-conceptualization of the problems of addicted, homeless women and children must include a gender, racial and class analysis of poverty. This analysis offers a strength-based explanation for the impoverished state of addicted homeless women with

children.

3) Affordable apartments in government- financed properties should allocate apartments to treatment programs to assist in the development of sober communities in low-income buildings, and to establish informal supports for families in recovery.

4) The harsh penalties (lack of access to government jobs and public housing) for felony convictions related to drugs should be reduced.

5) Child welfare authorities should make appropriate flexible assessments and referrals for women with substance abuse problems who are involved in negligence and abuse allegations.

6) The transition from welfare to financial independence requires affordable housing and childcare. Policies that provide subsidies for housing, childcare, educational and training programs are necessary to assist women who are hampered by lack of formal education and skills and a low-wage labor market.

7) Policies which reduce discrimination against women in the work place and increase employment opportunities are needed.

8) Childbearing and child-rearing for some women are more than a full time job and thus, work requirements imposed by welfare reform are punitive and likely unrealistic.

9) A variety of prevention programs for young children and their families are necessary. These prevention efforts must include not only drug education but recreational and educational after-school programs to engage children in constructive activities as well as to build self-esteem. Children as young as 8 or 9 years old are exposed to drugs and alcohol and vulnerable.

10) New York City family shelter's policies and regulations should require and finance training of shelter staff. These training should include but not be limited to identification of alcoholism and substance abuse, motivational counseling and appropriate transfers to tier II facilities that operate residential treatment programs and/or other treatment programs.

FUTURE RESEARCH

This study produced several preliminary findings which merit further examination. Both client and program characteristics associated with positive treatment outcomes need further research. It is critical that the specific aspects of a treatment process be examined to determine the most effective combination of treatment modalities for women and their children. This would allow for program replication and thus more effective services for addicted women. Research and evaluation are needed to determine which treatment modalities are most effective for women in general and for specific groups of women (CSAT, 1994). This may be of critical importance during this time when treatment programs are operating in a health care system which is in the midst of major change and reform.

Although there is a consensus in the field of addiction that women benefit from comprehensive services, the breadth of service is often dictated by program funding and linkage. Therefore, specific critical components of an integrated treatment system need to be examined to determine the necessary ingredients of effective programs that meet the

complex needs of women and children. The ramifications of successful maintenance of sobriety as defined by non-linear models of systems merit more investigation.

Post-treatment findings indicate that a few respondents relapsed due to relational and social stressors, while the majority coped with similar daily life stressors. Further research is necessary to focus on the cognitive and attitudinal changes associated with remaining sober and coping with life events.

The role of children was critical in the lives of these participants and more information would be useful in this area. Further studies could control for the time at which children were returned from foster care. Some residential programs allow parents to bring their children immediately upon admission to residential treatment, while others enforce a specific time-frame of six months or more. The effects of these time differences on treatment outcomes would be of importance to the field.

In addition, studies are needed which focus on the relationship between resources and supports and successful post-treatment recovery. One such study, for example, could investigate whether the quality of housing obtained, and the value of housing subsidies received are a predictor of relapse and/or a return to shelter living. Other variables related to the quality of housing and assistance should also be assessed in relationship to post treatment recovery.

Appendix A

Interview Guide

Opening statement: I am in the process of conducting interviews with women who have completed the Casa Rita program. I am looking to discover the personal characteristics, environmental factors and other factors that have contributed to your recovery from addiction. The purpose of this study is to identify these factors and share them with treatment programs and other women who are suffering from addiction. As you already know you are already role-models for other women who are still in their process of active addiction. I am particularly concerned with your view of what factors contributes to your recovery process. The information you give me is confidential within the limits of the law and will be presented anonymously in this study. Neither the tape or my interview notes will be shared. Before we begin do you have any questions?

I. HISTORY OF DRUG AND ALCOHOL PROBLEMS

1. How old were you when you first used any of the following?

Alcohol_____ hard liquor
_____ beer (malta)
_____ wine (coolers)

Drugs
_____ marijuana
_____ cocaine
_____ heroin
_____ amphetamines (speed)
_____ depressants (valium)
_____ other(if not listed)

2. What substance did you prefer?

3. At what age did you realize _____was a problem for you ?

12-15___
16-19___
20-22___
22-25___
26-29___
30-35___
36-39___
40-45___

4. Was there any life event that made you realize that substance abuse was a problem for you?

If Yes,_____
5. Did it involve:
Prompts: children
family members
loss of spouse/partner
loss of home.

II. PAST TREATMENT EXPERIENCES
1. Is this your 1st attempt at sobriety ? yes__ no__

2. How many times have you attempted treatment?
Detox only __
Inpatient drug or alcohol treatment__
Outpatient treatment__
3. Were any T.C approaches ?
Prompts: use of hot seats
confrontational techniques

4. How did you leave prior treatment ?
Prompts: completed
asked to leave
left on your own.
5. What was it about these programs that did not work for you?

Prompts: childcare
treatment approach
overwhelmingly male
rules and regulations

6. What more could have been done for you at that time?

7. What brought you to treatment in the past ?

8. What was different for you this last time ?

9. Why did you decide to come to Casa Rita ?

III. TREATMENT at CASA RITA
1. Was your experience at CR different from other programs?
Prompts: How so?
In what ways?
2. What was your opinion of specific aspects of the program such as:
Childcare
Acupuncture

Family therapy
The community of peers
Counselors
Groups
Predominantly women staff

Probes: positive, helpful, valuable, not useful, rigid

3. What are the qualities of Casa Rita that had an influence on you?
Prompts: community spirit, non-judgmental attitudes

4. Of the following what did you find most helped you in your success ?

individual counseling
group counseling
family counseling
network of peers

5. As you have successfully remained sober, have you continued with any relationships you developed at that time ?

IV. SUCCESS
1. What is the most important influence in helping you keep sober?
Prompts: your; Children
Family
Friends
Relationship to a higher power or God
2. In your view what is the single most important influence?
Prompts: family members
children
friends
loved ones
relationship to a higher power or God.

3. How/why does this influence have such an impact?

4. What is your braggiest version of how you are doing it,
Prompts: what have you done
how are you maintaining your sobriety?

5. Why do you think you have been successful in not using alcohol and drugs when others have not been?

6. Is there a particular friend, family member, belief or goal crucial to your recovery ?

7. Do you have a story or a time when you knew you had a chance at successfully becoming sober ?

V. COPING

1. Can you tell me a time when you felt low and might have in the past used alcohol /drugs but did not?
- What happened?
- What were the circumstances?
- Who else was involved?
- What did you feel ?
- What did you think ?
- What did you do ?
- what did it take ?

2. Who helps you to cope?

Prompt: friends
family
church
A.A., N.A.
spouse/mate

VI. COMMUNITIES

1. What outside supports help you to keep sober?

Prompts: A. A
N. A.
Church
friend
family
spouse/mate

2. Do you have a network of sober friends ?

Prompts : From WIN?
Sponsors?
A.A./N.A. members
friends
mate/spouse

3. How have these communities contributed to your sobriety?

Prompts: provide support
child-care
practical suggestions
financial support

VII. Employment

1. Have you ever been employed ? _____yes _____no.

2. How has substance abuse affected your work?
prompts: feedback from supervisors
terminated
quit work
3. Has sobriety affected your work?
Prompt: dealing with: Childcare issues
supervisors
co-workers
emergencies
Health Insurance
low pay rate

VIII. Housing

1. Have you ever held a lease for an apartment in your name prior to C.R.?

2. How has having your own lease impacted your relationships with family members and friends?

Prompt: set limits
housed other family members

3. What does having your own lease/ housing mean to you?

4. Do you feel the building is safe for you and your children ?
Prompts: drug availability
violence
noisy environment

5. Do you generally feel safe in the neighborhood where you live?
Prompts: friendly neighbors
" " shopkeepers
police protection

IX. Demographics

1. Age

2. How long sober as defined by not using any illicit drugs or alcohol ?

3. Often, when we fill out forms, we are asked to put ourselves in a descriptive category. How do you usually define yourself in these terms ?

Prompts: Mother, Recovering addict, HIV positive, Gay, Straight, Bisexual, Caucasian, African American, White/ Black Caribbean, Latina, Other

4. How many children do you have?
Prompts: Age
Gender
Living with you?
Lived with you during residential treatment?
Live in foster care or kinship care during treatment ?
If so, when were they returned?
Are any of your children currently in foster care?
Do you expect them to be returned?
If so when?

5. Are there any ideas that have not been covered that have contributed to your success?

6. What do you think is important that other women should know about the recovery process?

Appendix B

Letter to Participants

Dear _____,

I am presently attending the Hunter College of the City University of New York Doctoral Program in Social Welfare. I have decided to focus my research on women who have graduated from the Casa Rita residential treatment program. I have obtained your name and adress by Women In Need Inc. My specific interest is on identifying those strengths that have led you to a successful recovery process.

An aspect of the study is to interview former clients who have been in the recovery process. This interview will ask questions about your experiences with your recovery process and as a client of Casa Rita. This study is important because its findings will have a positive impact on treatment of women and children both at Casa Rita and other treatment programs.

Your answers to all questions are voluntary. All answers will be kept completely confidential. The interview will last about an hour. You may withdraw from this study at any time.

Your responses are very important to the goals of this research. A $ 10 fee will be given to compensate you for your time.

If you have any questions you can call me at 212-966-5295.

Sincerely,

_____

Maryanne Schretzman C.S.W.

Appendix C

Informed Consent Form

Instructions to the Research participant: Please read the Following Carefully:

Participation in this study is voluntary. There will be no penalty or loss should you decide not to participate. Withdrawal from this study at any time, even after you begin, will not affect you in anyway.Your identity as a participant in this research will remain confidential with regard to any publications and oral presentations of the results of this study. Your records in this study will be kept confidential to the extent permitted by law.

Your response will be reported anonymously and your identity disguised if any response could reveal your identity.If you believe you have experienced any problems as a result of your participation in the research you should contact: Michael Smith D.S.W. Professor, Hunter College School of Social Work.129 East 79th Street. Phone# 212 452-7029

Purpose of the study:In depth-interviews will be conducted in order to understand 1) what does it take to sustain sobriety after treatment, 2) what are the obstacles to maintaining drug and alcohol free, and to what extent are these individual, relational or environmental; 3) what relationships are a source of support; 4) what are the important aspects of treatment. The objective of this study is to further understand post-treatment predictors in order to improve existing and developing programs for homeless women with children.

As a participant, I will be asked to do the following:-participate in an interview and answer questions about my recovery process in the Casa Rita treatment program and post- treatment. Most questions will focus on the positive aspects of this process.-identify those internal and external supports and strengths that enable my recovery process.- consent to tape record the interview, which will be destroyed or returned to you within 48 hours after I transcribe the interview. The interview material is kept confidential and the tapes will not be used for any other purpose other than this study. If the tape recorder is uncomfortable, I will take notes. - review of my clinical record and the use of some appropriate data from that record.

The following risks may be involved as a result of my participation:- recalling the recovery process may bring up some painful memories or emotional reactions of your addiction experience and previous attempts at recovery. If this should occur, a Women In Need after-care counselor will be available to provide counseling services to you. If you prefer to obtain counseling elsewhere a referral will be provided.

Limits of Confidentiality:

As a certified social worker, I am obliged to follow ethical codes of conduct. Information related to harm to yourself or your children, such as hurting your children cannot be kept confidential. I will report these activities to the appropriate authorities so that you and others can be safe as possible. With this knowledge about what the limits are, I hope you will, nevertheless, speak to me about your experiences as openly as you can.The following benefits are expected to result from the study:

-to utilize your positive experiences to assist helping others in their recovery process.

-to document the success of the clients in this program and emphasize that treatment works for women with children.I_____, volunteer to participate in the research study under the supervision of Maryanne Schretzman. I understand the information provided about what I will be asked to do as a participant, and I have had the opportunity to ask questions with respect to my participation. _____Signature of Participant - Date

ASI Introduction

POINTS TO INCLUDE WHEN INTRODUCING THE INTERVIEW

----All clients get this same interview.

----All of the information gathered is confidential and will be used only by the treatment/research staff.

----The interview consists of seven parts, i.e., medical, family/social, employment/support, psychological, legal, and drug/alcohol use.

----There will be two time periods addressed, the past 30 days and lifetime data.

----Client input is important. For each area I will ask you to use a scale to let me know how bothered you have been by any problems in each section. Also, I will ask you how important treatment is for you for the area being discussed. The scale is:

0 not at all
1 slightly
2 moderately
3 considerably
4 extremely

The interviewer should mention each of these points. The most important consideration is that the client understands the point of the interview which is to get a complete history of the client so that we can tailor our services to her needs.

GENERAL INFORMATION (The first 10 items can be filled out by interviewer alone.)

*1. Client ID #: :__:__:__:__:__:__:__:__:__:
Initials mo day yr
(D.O.B.)

*2. Date of Interview :__:__:__:__:__:__:
mo day yr

3. Date of 1st team contact: :__:__:__:__:__:__:
mo day yr

*4. Class:
1-Intake
2-Follow-up

5. Hotel:
1-Bryant
2-Prince George

*6. Staff Code Number :__:__:

7. Sex:
1-Male
2-Female

* Indicates an item that appeared on the original Addiction Severity Index (ASI) (McLellan, 1980). Give these items priority if it becomes necessary to shorten the length of the interview.

*8. Special:
1-Client terminated
2-Client refused
3-Client unable to respond
N-Interview completed

9. Referral Source:
1-Self
2-Outreach Team
3-Family
4-Court, police
5-Service Agency
6-Other
Please specify: _____

10. English Speaking? 1-No 2-Yes

11. Name _____

12. Room Number (Address) _____

13. Telephone Number |__|__|__| |__|__|__|-|__|__|__|__|

*14. How long have you lived here? |__|__|__|__|
yrs mos

15. U.S. Citizen?
1-No (GO TO #15) 2-Yes (GO TO #17)

16. Country of Birth: _____

17. Alien registration # |__|__|__|__|__|__|__|__|__|

*18. S.S.# |__|__|__|-|__|__|-|__|__|__|__|

19. AFDC Number: |__|__|__|__|__|__|__|-|__|

*20. What is your race?
1-White (not of hispanic origin)
2-Black (not of hispanic origin)
3-American Indian
4-Alaskan Native
5-Asian or Pacific Islander
6-Hispanic-Mexican
7-Hispanic-Puerto Rican
8-Hispanic-Cuban
9-Other Hispanic

21. In addition to race, some people identify with a culture or ethnicity. Do you?
1-NO 2-YES

21a. If so , what?_____

*22. Do you have a religious preference?
1-Protestant 3-Jewish 5-Other
2-Catholic 4-Islamic 6-None

*23. Have you been in a controlled environment in the past 30 days?
1-No
2-Jail
3-Alcohol or Drug treatment
4-Medical treatment
5-Psychiatric treatment
6-Other _____

*23a. If yes, --> How many days? |__|__| N-not applicable

24. What other agencies are involved with your family?

Agency name	Address	Contact person	Phone

25. In an emergency, who would you want contacted?

Name _____

Relationship to you _____

Address _____

Phone Number |__|__|__| |__|__|__|-|__|__|__|__|

FAMILY/SOCIAL RELATIONSHIPS

1. Who are the members of your family?

*Codes: c=Primary caretaker of children
p=Pregnant
f=In foster care
a=Living elsewhere but not in foster care.

Code	Name	Relationship	DOB

*2. Marital Status:

1-Married 4-Separated 7-Common law
2-Remarried 5-Divorced
3-Widowed 6-Never married

*3. How long have you been in this marital status? |__|__|__|__|
(If never married, since 18) yrs mos

*4. Are you satisfied with this situation?

1-No 2-Indifferent 3-Yes

*5. In the last 3 years who have you lived with?
(Interviewer: Circle the choice that describes the most typical living arrangements)

1-with sexual partner and children
2-with sexual partner alone
3-with children alone
4-with parents
5-with other family
6-with friends
7-alone
8-controlled environment
9-no stable arrangements
10-with parents & children
11-with parents, children & sexual partner

*6. How long did you live in these arrangements? |__|__|__|__|
(If with parents, or family, since 18) yrs mos

*7. Were you satisfied with these living arrangements?
1-No 2-Indifferent 3-Yes

*8. With whom do you spend most of your free time?
1-family (Includes spouse/sexual partner) 3-alone
2-friends

*9. Are you satisfied with spending your free time this way?
1-No 2-Indifferent 3-Yes

*10. How many close friends do you have? |__|__|

11. When you have a problem, who do you turn to for help?
1-spouse/sexual partner
2-mother
3-father
4-sister/brother
5-friend
6-other _____ (specify)

*12. How many days in the past 30 have you had major problems:
(Interviewer: Examples of major problems are serious arguments or conflicts that may endanger the relationship.)
1-with your family? |__|__| 2-with other people? |__|__|

*13. Have you had a long period of time in which you have experienced major problems (like poor communication, hostility, a complete lack of trust) with your:
1-No 2-Yes N-not applicable/no contact in 6 mos.

	Lifetime	Past 30 Days
Mother	|__|	|__|
Father	|__|	|__|
Brothers/Sisters	|__|	|__|
Sexual partner/spouse	|__|	|__|
Children	|__|	|__|
Other significant family _____ (specify)	|__|	|__|
Close friends	|__|	|__|
Neighbors	|__|	|__|
Co-workers	|__|	|__|

14. Were any of the problems you just mentioned related to alcohol or drug use/abuse? (can be either client's use or other's use)
    1-No 2-Yes

15. How long has it been since you had a place to live that you consider to be a permanent home? ¦__¦__¦__¦__¦__¦__¦
    yrs mos wks

16. What do you consider to be the main reason(s) for your being homeless now?
    1-fire
    2-building problems
    3-eviction
    4-unable to continue "doubling up" with other family or friends
    5-illness
    6-domestic violence
    7-could not afford rent
    8-other

FOR THE FOLLOWING 2 QUESTIONS, PLEASE ASK THE CLIENT TO USE THE RATING SCALE.

*17. How troubled or bothered have you been in the past 30 days by these:
    ¦__¦ family problems we just discussed?
    ¦__¦ problems with friends, neighbors, and others that you just told me about?

*18. How important to you now is treatment or counseling for these:
    ¦__¦ family problems?
    ¦__¦ problems with others?

INTERVIEWER SEVERITY RATING

*19. How would you rate the client's need for family and/or social counseling? ¦__¦

CONFIDENCE RATING

*20. Is the above information significantly distorted by:
    client's misrepresentation
    1-No 2-Yes

*21. client's inability to understand
    1-No 2-Yes

COMMENTS

EMPLOYMENT/SUPPORT STATUS

*1. How far did you go in school?: ¦__¦__¦__¦__¦
yrs mos

*2. Training or technical education: ¦__¦__¦
mos

2a. Did you complete the training course? 1-No 2-Yes 3-N

*3. Do you have a profession, trade, or skill?
(Generally a profession, trade or skill is acquired through specialized training)
1-No 2-Yes Specify _____

*4. How long was your longest full-time job? ¦__¦__¦__¦__¦
yrs mos

5. Why did you leave that job? _____
_____

*6. Usual occupation:(if client has no usual occupation, use last occupation)

_____
(specify in detail)

*7. Usual employment pattern, past 3 years
1-full time (40 hrs/wk)
2-part time (reg hrs)
3-part time (irreg daywork)
4-student
5-service
6-retired/disability
7-unemployed
8-homemaker
9-in controlled environment

*8. How many days were you paid for working in the past 30? ¦__¦__¦
(Include "under the table" work.)

*9. Does anyone (family or friend) contribute to your financial support on a regular basis in any way?
1-No 2-Yes

*10. Does this support constitute the majority of your support?
1-No 2-Yes 3-N

*11. How much money did you receive from the following sources in the past 30 days?

|__|__|__|__| Employment (net income)

|__|__|__|__| Unemployment Comp.

|__|__|__|__| AFDC, welfare, Food Stamps

|__|__|__|__| Pension benefits or social security

|__|__|__|__| Mate, family, friends, lottery, or numbers (Includes gifts, loans, winnings)

***|__|__|__|__| Illegal

*12. How many people besides yourself depend on you for the majority of their food, shelter, etc? |__|__| (Exclude client)

13. Have you looked for work in the last 30 days?
1-No (GO TO MEDICAL STATUS SECTION) 2-Yes (GO TO #14)

*14. How many days have you experienced problems with your job or have been unable to find a job in the past 30? |__|__|

FOR THE FOLLOWING 2 QUESTIONS, PLEASE ASK THE CLIENT TO USE THE RATING SCALE.

*15. How troubled or bothered have you been by these employment problems in the past 30 days? |__|

*16. how important to you now is counseling for these employment problems? |__|

INTERVIEWER SEVERITY RATING

*17. How would you rate the client's need for employment counseling? |__|

CONFIDENCE RATING

*18. Is the above information significantly distorted by:
client's misrepresentation?
1-No 2-Yes

*19. client's inability to understand?
1-No 2-Yes

COMMENTS

MEDICAL STATUS

*1. How many times in your life have you been hospitalized overnight for medical problems? (such as surgery, major illness, etc) ¦__¦__¦

*2. Of the total number of hospitalizations, how many were for pregnancy related treatment or childbirth? ¦__¦__¦

*3. Of the total, how many were for detox? ¦__¦__¦

*4. How long ago was your last overnight hospitalization for a medical problem? ¦__¦__¦__¦__¦ (N-Not applicable)
yrs mos

*5. Do you have any medical problems which require special attention or which continue to interfere with your life?
1-No 2-Yes

5a. If yes, what is the problem? _____

*6. Are you taking any prescribed medication on a regular basis for a physical problem?
1-No 2-Yes

6a. If yes, specify _____

*7. Do you receive SSI or Social Security Disabilty for a physical disability? (exclude a psychiatric disability)
1-No 2-Yes

*7a. If yes, specify the disability _____

*8. How many days have you been troubled or bothered by medical problems in the past 30 days? (Medical problems include chronic ones as well as colds, flu or other minor illnesses) ¦__¦__¦

FOR THE FOLLOWING 2 QUESTIONS, PLEASE ASK THE CLIENT TO USE THE RATING SCALE.

*9. How troubled or bothered have you been by the medical problems you mentioned in the past 30 days? ¦__¦

*10. How important to you now is treatment for these medical problems? ¦__¦

INTERVIEWER SEVERITY RATING

*11. How would you rate the client's need for medical treatment?
¦__¦

CONFIDENCE RATINGS

*12. Is the above information significantly distorted by:

client's misrepresentation?
1-No 2-Yes

*13. client's inability to understand?
1-No 2-Yes

COMMENTS

PSYCHOLOGICAL STATUS

*1. How many different times in your life have you been treated for any psychological, emotional or nervous condition:

__ __: As a hospital inpatient?
__ __: As an outpatient or private patient?

2. Do you have any emotional, psychological or nervous problems which require special attention or continue to interfere with your life.?

1-No 2-Yes ---> Specify _____

*3. Do you receive SSI or Social Security Disabilty for a psychiatric disability?
1-No 2-Yes

*4. Have you had a period of 5 days or more in which you have:
(Interviewer: Record/Count only experiences which seem unrelated to alcohol/drug use)
1-No 2-Yes

	Lifetime	Past 30 days
Experienced serious depression	¦__¦	¦__¦
Experienced serious anxiety, tension or nervousness	¦__¦	¦__¦
Experienced trouble understanding, concentrating or remembering	¦__¦	¦__¦
Experienced serious problems with sleeping or eating	¦__¦	¦__¦

*5. Have you ever:

1-No 2-Yes

	Lifetime	Past 30 days
Experienced hallucinations	¦__¦	¦__¦
Experienced trouble controlling violent behavior	¦__¦	¦__¦
Experienced serious thoughts of suicide	¦__¦	¦__¦
Attempted suicide	¦__¦	¦__¦
taken prescribed medication for psychological/emotional problems?	¦__¦	¦__¦

6. Are you <u>now</u> taking any prescribed medication for a psychological/emotional problem?
1-No 2-Yes

*7. How many <u>days</u> in the past 30 have you experienced the psychological or emotional problems that we just discussed? ¦__,__¦

<u>FOR THE FOLLOWING 2 QUESTIONS, PLEASE ASK THE CLIENT TO USE THE RATING SCALE.</u>

*8. How much have you been troubled by the psychological or emotional problems you described in the past 30 days? ¦__¦

*9. How important to you now is further treatment for these psychological problems? ¦__¦

THE FOLLOWING ITEMS ARE TO BE COMPLETED BY THE INTERVIEWER.

*10. At the time of the interview, is the client:

1-No	2-Yes	
¦__¦		Obviously depressed/withdrawn
¦__¦		Obviously hostile
¦__¦		Obviously anxious/nervous
¦__¦		Having trouble with reality testing, thought disorders, paranoid thinking
¦__¦		Having trouble comprehending, concentrating, remembering
¦__¦		Having suicidal thoughts

INTERVIEWER SEVERITY RATING

*11. How would you rate the client's need for psychiatric or psychological treatment? ¦__¦

CONFIDENCE RATING

*12. Is the above information significantly distorted by: client's misrepresentation?
1-No 2-Yes

*13. client's inability to understand?
1-No 2-Yes

COMMENTS

DRUG/ALCOHOL USE

*1. Use, including prescription use
(Interviewer: Record Lifetime use when consumption was steady for 1 month or more, and happened at least 3 times per week.)

	Past Month # of Days	Lifetime Yrs	Lifetime Mos
01-Alcohol-Any use at all	¦__¦__¦	¦__¦__¦	¦__¦__¦
02-Alcohol-To intoxication (High or buzzed)	¦__¦__¦	¦__¦__¦	¦__¦__¦
03-Heroin	¦__¦__¦	¦__¦__¦	¦__¦__¦
04-Methadone, LAAM	¦__¦__¦	¦__¦__¦	¦__¦__¦
05-Other opiates/analgesics (Morphine, Demerol, Darvon)	¦__¦__¦	¦__¦__¦	¦__¦__¦
06-Barbiturates/Barbs (Seconals/REDS, Tuinals/RAINBOWS, PURPLE HEARTS)	¦__¦__¦	¦__¦__¦	¦__¦__¦
07-Other sed/hyp/tranq (Quaaludes, Valium, Librium)	¦__¦__¦	¦__¦__¦	¦__¦__¦
08-Cocaine/Crack	¦__¦__¦	¦__¦__¦	¦__¦__¦
09-Amphetamines (BENNIES, SPEED, UPPERS, DEXIES, CRANK)	¦__¦__¦	¦__¦__¦	¦__¦__¦
10-Cannabis (POT, REEFER)	¦__¦__¦	¦__¦__¦	¦__¦__¦
11-Hallucinogens (LSD/ACID, Mescaline/MESC PCP/ANGEL DUST)	¦__¦__¦	¦__¦__¦	¦__¦__¦
12-Inhalants (Nitrous oxide/WHIPPETS, Glue, Amyl Nitrate/POPPERS)	¦__¦__¦	¦__¦__¦	¦__¦__¦
13-More than 1 substance per day (Include alcohol)	¦__¦__¦	¦__¦__¦	¦__¦__¦

Give examples for 13 _____

NOTE: SEE MANUAL FOR ADDITIONAL REPRESENTATIVE EXAMPLES FOR EACH LISTED ABOVE.

COMMENTS

*2. Interviewer: Which substance do you think is the major problem?

_____

*3. How long was your most recent period of voluntary abstinence from _____? ¦__¦__¦__¦__¦__¦__¦
(the substance listed in the previous question) yrs mos days

(Interviewer: Exclude abstinence due to hospitalization or incarceration

*4. How long ago did this abstinence end? ¦__¦__¦__¦__¦__¦__¦
N-Not applicable yrs mos wks

5. Have any of the following ever been a problem for you?
1-No 2-Yes

gambling ¦__¦
eating disorders ¦__¦
sexual compulsivity ¦__¦

*6. How many times have you:

¦__¦__¦ Had alcohol d.t.'s?

¦__¦__¦ Had flashbacks (Experiencing sensations associated with alc/drug use while being sober)

¦__¦__¦ Overdosed on drugs? (Requiring help from someone)

¦__¦__¦ Had blackouts (Functioning without recall)

*7. How many different times in your life have you been treated for: (Include self-help groups if they attended at least 3 times for 1 month)

¦__¦__¦ Alcohol problems?

¦__¦__¦ Drug problems?

*8. How many of these were detox only? (N-Not applicable)

¦__¦__¦ Alcohol

¦__¦__¦ Drug

*9. How much would you say you spent during the past 30 days on:

¦__¦__¦__¦__¦ Alcohol?

¦__¦__¦__¦__¦ Drugs?

*10. How many days have you been treated in an outpatient setting for alcohol or drugs in the past 30 days? (Include NA & AA)
¦__¦__¦

*11. How many days in the past 30 have you experienced adverse effects, withdrawal symptoms, or cravings related to:

¦__¦__¦ Alcohol use?

¦__¦__¦ Drug use?

12. Have any of the following family members ever had an alcohol or drug problem?

1-No 2-Yes 3-N

¦__¦ Mother	¦__¦ Brother	¦__¦ Spouse/sexual partner
¦__¦ Father	¦__¦ Sister	
¦__¦ Other Guardian	¦__¦ Children	

FOR THE FOLLOWING 2 QUESTIONS, PLEASE ASK THE CLIENT TO USE THE RATING SCALE.

*13. How troubled or bothered have you been in the past 30 days by the:

¦__¦ Alcohol problems which you just described?

¦__¦ Drug problems which you just described?

*14. How important to you now is treatment for these:

¦__¦ Alcohol problems

¦__¦ Drug problems

INTERVIEWER SEVERITY RATING

*15. How would you rate the client's need for treatment for:

¦__¦ Alcohol abuse

¦__¦ Drug abuse

CONFIDENCE RATINGS

*16. Is the above information significantly distorted by:

client's misrepresentation?
1-No 2-Yes

*17. client's inability to understand?
1-No 2-Yes

LEGAL STATUS

*1. Was this contact with the outreach team prompted or suggested by the criminal justice system? (judge, probation/parole officer, SSC worker, etc)
1-No 2-Yes

*2. How many times in your adult life have you been arrested and charged with the following criminal offenses?

# of arrests			# of counts	
¦__¦	¦__¦	shoplifting	¦__¦	¦__¦
¦__¦	¦__¦	parole/probation violations	¦__¦	¦__¦
¦__¦	¦__¦	drug charges	¦__¦	¦__¦
¦__¦	¦__¦	forgery	¦__¦	¦__¦
¦__¦	¦__¦	weapons offense	¦__¦	¦__¦
¦__¦	¦__¦	burglary, larceny, B&E	¦__¦	¦__¦
¦__¦	¦__¦	robbery	¦__¦	¦__¦
¦__¦	¦__¦	assault	¦__¦	¦__¦
¦__¦	¦__¦	arson	¦__¦	¦__¦
¦__¦	¦__¦	homicide, manslaughter	¦__¦	¦__¦
¦__¦	¦__¦	child abuse, neglect	¦__¦	¦__¦
¦__¦	¦__¦	prostitution	¦__¦	¦__¦
¦__¦	¦__¦	other		

*3. How many of these charges resulted in convictions? ¦__¦__¦
(N-Not applicable)

*4. How many times in your life have you been charged with the following?

¦__¦__¦ disorderly conduct, vagrancy, public intoxication
¦__¦__¦ driving while intoxicated
¦__¦__¦ major driving violations
(reckless driving, speeding, no license, etc)
¦__¦__¦ jumping the turnstile

*5. How many months were you incarcerated in your life? |__|__|
mos

*6. How long was your last incarceration? |__|__|
(N-Not applicable) mos

*6a. What was it for? _____
(N-Not applicable)

*7. How many days in the past 30 were you detained or incarcerated? |__|__|

***8. How many days in the past 30 have you engaged in illegal activities for profit? |__|__|

9. How many times have you been a victim of one of the following crimes?

|__|__| assault
|__|__| arson
|__|__| rape
|__|__| domestic violence
|__|__| child abuse, neglect
|__|__| robbery
|__|__| sexual exploitation

10. Have you ever had to get an order of protection?
1-No 2-Yes

11. Do you have any legal problems involving family court, juvenile court or SSC (Examples: custody cases, divorces, etc)
1-No 2-Yes---> Specify _____

*12. Are you on probation or parole?
1-No 2-Yes

12a. If yes--> Name of probation/parole officer _____

*13. Are you presently awaiting trial or sentence?
1-No 2-Yes

*13a. If yes, what for? _____

13b. If yes, ask for following additional information: (If judged necessary or important)

Charge date |__|__|__|__||__|__| Docket Indictment # _____
mo day yr

Court date |__|__|__|__|__|__| Name of Judge _____
mo day yr

Name of court _____

Address of court _____

FOR THE FOLLOWING 2 QUESTIONS, PLEASE ASK THE CLIENT TO USE THE RATING SCALE.

*14. How serious do you feel your present legal problems are?
¦__¦

*15. How important to you now is counseling or referral for these legal problems? ¦__¦

INTERVIEWER SEVERITY RATING

*16. How would you rate the client's need for legal services or counseling? ¦__¦

CONFIDENCE RATING

*17. Is the above information significantly distorted by:

client's misrepresentation?
1-No 2-Yes

*18. client's inability to understand?
1-No 2-Yes

COMMENTS

CONCLUSION

1. Of all the problems that you may be concerned about, which do you think you need to get help with right now?

1-family problems	09-home management
2-health problems	10-child school/behavior problems
3-alcohol problems	11-employment
4-education	12-counseling
5-housing	13-entitlements advocacy
6-food/clothing	14-substance abuse
7-child care	15-emotional problems
8-domestic violence	16-other

2. Which do you think is most important? _____
(Interviewer: If you disagree with the client's assessment of importance, indicate your perceptions below.)

REFERENCES

_____. Where The Homeless Come From: A Study of the Prior Address Distribution of Families Admitted to Public Shelters in New York City and Philadelphia. Working Paper Washington D.C.: Fannie Mae.

Abramovitz, M.. (1988). Regulating The Lives of Women Social Welfare Policy From Colonial Times to the Present. Boston, MA: South End Press.

Alaszewski, A. and Harrison, L. (1992). Alcohol and Social Work; A Literature Review. British Journal of Social Work, 22, 331-344.

Alcoholic Anonymous(1953). Alcoholics Anonymous. New York: Author.

ANYCAP. (1996). Association of New York City Addiction Program. Topic discussed at monthly meeting. April12, 1993.

Ball, J.C. and Ross, A. (1991). The Effectiveness of Methadone Maintenance Treatment. New York: Spinger-Verlag.

Ballou, J. (1978). The Significance of Reconciliative Themes in the Psychology of Pregnancy .Bulletin of The Menninger Clinic, 42, 383-413.

Bane, M.J. (1986). "Household Composition and Poverty". In S.H. Danzinger and D.H. Weinberg (Eds.) Fighting Poverty: What Works and What Doesn't. Cambridge, MA.:Harvard University Press.

Banyard, V.L. and Graham-Bermann, S.A.(1995). Building an Empowerment Policy Paradigm: Self Reported Strengths of Homeless Mothers. American Journal of Orthopsychiatry, 65, (4), 479-491.

Barber, J. (1995). Working with Resistant Drug Abusers. Journal of Social Work, 40, (1),17-24.

Barrios-Paoli, Lillian. (1997). HRA Fact Sheet: October. Human Resource Administration of the City of New York.

Bass, Ellen (1988).The Courage To Heal: A Guide for Women Survivors of Child Sexual Abuse 1st. Edition New York: Harper and Row.

Bassuk, E.L. and Rosenberg, L.(1988) Why Does Family Homeless Occur? A Case Control Study. American Journal of Public Health, 76, 783-788.

Bassuk, E.L. and Rubin, L. & Lauriat, A.S. (1986) Characteristics of Sheltered Homeless

Families. American Journal of Public Health, 76, (9),1097-1101.

Bateson, G. (1972). Steps to an Ecology of Mind. New York : Ballantine Books.

Baum, A. S. & Burnes D. W. (1993). A Nation in Denial: The Truth about Homelessness. Boulder Co.: Westview Press.

Beckman, L., (1994). Treatment Needs of Women with Alcohol Problems. Alcohol and Research World, 18, (3),101-114.

Beckman, L. J., & Amaro, H. (1984). Patterns of Women's Use of Alcohol Treatment Agencies. In S.C. Wilsnack & L.J. Beckman (Eds.),Alcohol and Problems in Women. New York: Guilford Press.

Berger, C. S., Sorenson, L., Gendler, B. and Fitzsimmons, J. (1990). Cocaine and Pregnancy: A Challenge for Health care Providers. Health and Social Work, 15,(4), 310-316.

Bingol, N., Schuster, C., Fuchs, M. Iosa, S., Turner, G., Stone, R.K.and Cromish, D.S. (1987). The Influence of Socioeconomic Factors in the Occurence of Fetal Alcohol Syndrome. Advances in Alcoholism and Substance Abuse, 6,(4),105-118.

Black, T.R.(1993). Evaluating Social Science Research: An Introduction. California: Sage Publications.

Blocker, J. S. (1989). American Temperance Movements: Cycles of Reform. MA.:Twayne Publisher.

Blume, S.B. (1997). Women Clinical Aspects. In Lowinson, et. al. Eds. Substance Abuse A Comprehensive Textbook, 3rd. Ed.

Blume, S.B. (1990). Chemical Dependency In Women: Important Issues. American Journal of Drug and Alcohol Abuse, 16, (3&4), 297-307.

Bradshaw, J. (1988). Healing the Shame that Binds You. Health Communications: Florida.

Brudenell, I..(1996). A Grounded Theory of Balancing Alcohol Recovery and Pregnancy. Journal of Nursing Research, 18, (4),429-436.

Burgess, A. (1985) Rape and Sexual Assault: A Research Handbook. New York: Garland Publishers.

Burke, A.C.and Clapp, J.D. (1997). Ideology and Social Work Practice in Substance Abuse Settings. Journal of Social Work, 42, (6), 552-564.

Burt, M.R. & Cohen, B.E. (1989). Differences Among Homeless Single Women, Women With Children, and Single Men. Journal of Social Problems, 36, 508-524.

Burt, Martha R. (1992). Over The Edge: The Growth of Homelessness in the 1980's. New York: Russel Sage Foundation.

Byington, D.B. (1997) Applying Relational Theory to Addiction Treatment. In S.L. A. Straussner and E. Zelvin Eds. Gender and Addictions: Men and Women in Treatment. New Jersey: Jason Aronson Inc.

Califano, J.(1996). Substance Abuse and the American Woman. New York: The National Center on Addiction and Substance Abuse at Columbia University.

Carroll, K.M., Power, M.E. D., Bryant, K., & Rounsaville, B.J. (1993). One Year Follow-Up Status of Treatment Seeking Cocaine Abusers: Psychopathology and Dependence Severity as Predictors of Outcome. Journal of Nervous Mental Disorders, 181, (2),71-80.

CCS. (1997). Keeping Track of New York City Children. Citizens Committee on Children. New York, New York.

Center for Substance Abuse Treatment (CSAT). (1994). Practical Approaches in the Treatment of Women Who Abuse Alcohol and Other Drugs. U.S. Department of Health and Human Services Public Health Service. Substance Abuse and Mental Health Services Administration. Center for Substance Abuse Treatment Program. Women and Children's Branch. Rockville, MD.

Center for Substance Abuse Treatment (CSAT). (1993). Program Announcement for Residential Treatment for Pregnant and Postpartum Women. United States Department of Health and Human Services. Public Health Service. Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment. Program Announcement No.AS-93-03.

Chavkin, W., Kristal, A., Seabron, C., Guigli, P. (1987). The Reproductive Experience of Living in Hotels for the Homeless in New York City. New York State Journal of Medicine, 87, 10-13.

Chavkin, W., Walker, B., Peone, D.(1992). Drug Using Families and Child Protection. Paper Presentation. Beth Israel Hospital Forums. Beth Israel Hospital: New York

Chavkin, W. (1990). Drug Addiction and Pregnancy: Policy Crossroads. American Journal of Public Health, 80, (4),483-487.

Chitwood, D.D.(1985). Patterns and Consequences of Cocaine Use. In Cocaine Use in Americans: Epidemiologic and Clinical Perspectives. Washington D.C. National Institute on

Drug Abuse, ResearchMonograph No.61.

Chodorow, N. (1978). The Reproduction of Mothering: Psychoanalysis and Sociology of Gender. Berkeley, California: University of California Press.
Clayton, R., Voss, H, Robbin, C, and Skinner,W.(1985). Gender Preferences in Drug Use: An Epidemiological Perspective. NIDA Research Monograph 65. Rockville, Md.: National Institute on Drug Abuse.

Clemmons, P. (1986). Social Thought in the 20th Century as it Relates to Research on Women, Alcohol and Alcoholism. In T. Watts Ed. Social Thought on Alcoholism. Krieger Publishing.

Cohen, J. and Levy, S. (1992). The Mentally Ill Chemical Abuser: Whose Client? New York: Lexington Books.

Cohen, E. and Stahler,G.J.(1998). Life Histories of Crack -Using African-American Homeless Men: Salient Themes. Contemporary Drug Problems, 25, 373-395.

Collins, P.H. (1991). Black Feminist Thought. New York: Rutledge Press.

Coltoff, P. and Alfaro, J.D.(1996). Ensuring Protection of Children of Drug Addicted or Alcoholic Parents: Proposals to Amend the New York Family Court Act. Childrens Aid Society N.Y. N.Y.

Conrad, K.J., Hultman, C.I.,and Lyons,J.S.(1993). Treatment of the Chemically Dependant Homeless: A Synthesis. Alcoholism Treatment Quarterly, 10, (3&4),1-4.

Corrigan, E. M. (1987). Women's Combined Use of Alcohol and Other Mind-Altering Drugs. In D. Burden & N. Gottleib (Eds.) The Woman Client. New York: Tavistock.

Corrigan, E. M. (1980). Alcoholic Women in Treatment. New York: Oxford University Press.

Covington, S.S. (1982). Sexual Experience, Dysfunction, and Abuse: A Comprehensive Study of Alcoholic and Nonalcoholic Women. Unpublished Doctoral Dissertation. Union Graduate School, Cincinnati, Ohio.

Culhane, D.P.(1998). Predictors of Exit and Reentry of Shelter Use In New York City. Unpublished Paper. New York City Department of Homeless Services.

Cuomo, A. (1992). The Way Home : A New Direction in Social Policy. A report of the New York City Commission on the Homeless.

Curran, F. (1937). 1937 Personality Studies in Alcoholic Women. The Journal of Nervous

and Mental Disease. 86, 12-32.

D'Ercole, A. and Struening, E. (1990). Victimization Among Homeless Women. Journal of Community Psychology, 18, 141-152.

Daghestani, A. (1988). Psychological Characteristics of Pregnant Women Addicts in Treatment. In Drugs, Alcohol, Pregnancy, and Parenting, Edited by I. Chasnoff. Boston:Kluwer Academic Publishers.

DeLeon, George (1994). The Theraputic Community: Toward a General Theory and Model. In F. Tims, G. DeLeon, and N.Jainchill Therapeutic Community : Advances In Research and Application. NIDA Research Monagraph #144. National Institute on Drug Addiction: Rockville, M.D.

DeLeon, G., Incardi, J. A.,Steven, S. and Martin, M.(1995). Residential Drug Abuse Treatment Research: Are Conventional Control Design Appropriate for Assessing Treatment Effectiveness? Journal of Psychoactive Drugs, 27, (1), 85-91.

Devine, J. A. and Wright, J.D.(1997). Losing the Housing Game: The Leveling Effects of Substance Abuse. Journal of Orthopsychiatry, 67, (4),618-631.

Dolbeare, C.N.(1989). Out of Reach: Why Everyday People Can't Find Affordable Housing. Washington, D.C.: Low Income Housing Information Service.

Dore, M.M., Doris, J. M., & Wright, P. (1995). Identifying Substance Abuse in Maltreating Families: A Child Welfare Challenge. Journal of Child Abuse and Neglect, 19, (5),531-543.

Downs, W.R., Miller, B.A. And Panek, D.D. (1993). Differential Patterns of Partner to Woman Violence: A Comparison of Samples of Community, Alcohol-Abusing, and Battered Women. Journal of Family Violence, 8, 113-149.

Dulfano, C.(1985). Family Therapy of Alcoholism . In S. Zimberg, J. Wallace, and S.B. Blume. Practical Approaches to Alcoholism Psychotherapy. New York: Plenum Press.

Emergency Alliance for Homeless Families and Children. (1997).Final Report on Homeless Families 1997. Citizens' Committee for Children of New York. 105 East 22nd St .New York,N.Y.

Ettorre, E. (1992). Women and Substance Abuse. New Brunswick, N.J. Rutgers University Press.

Faupel, C.E.and Hanke, P.J.(1993) A Comparative Analysis of Drug Using Women With and Without Treatment Histories in New York City. The International Journal of Addictions, 28. (3),233-247.

Finkelstein, N., Duncan, S., Derman, and Smeltz, J. (1990). Getting Sober Getting Well. Casper: Cambridge, Massachusetts.

Finkelstein, N. and Derman, L. (1991). Single Parent Women: What A Mother Can Do.In P. Roth (Ed.) Alcohol and Drugs are Women's Issues. Metuchen N.J.:Scarecrow Press.

Fiorentine, R., Anglin, M.D., Gil-Rivas,V., and Taylor, L. Drug Treatment : Explaining The Paradox. In Press. Copies available at Drug Abuse Research Center: University of California Los Angeles.

Fisher, P.J., Breakley, W.R., Nestadt, A.(1992).Victimization in Two Samples of Homeless Women. Paper presented at the American Public Health Association (APHA). Washington D.C. Nov.1992.

Forth-Finegan, J. (1991). Sugar and Spice and Everything Nice: Gender Socialization and Women's Addiction-A Literature Review. In C. Bepko (Ed.) Feminism and Addiction, New York: Haworth Press.

Fraser, M. W. (1996). Aggressive Behavior in Childhood and Early Adolescence: An Ecological-Developmental Perspective on Youth Violence. Journal of Social Work, 41, (4),347-363.

Freeman, E.M. (1992). The Addiction Process : Effective Social Work Approaches. New York: Longman Publishing.

Germain, C.B., and Gitterman, A.(1986). The Life Model Approach to Social Work Practice Revisited. In F. Turner (Ed.) Social Work Treatment : Interlocking Theoretical Approaches. New York: The Free Press.

Germain, C. B. and Gitterman, A. (1980). The Life Model of Social Work Practice. New York: Columbia University Press.

Germain, C.B. (1981). The Ecological Approach to People -Environment Transactions. Journal of Social Casework, 62, (6),323-331.

Gilligan, C., (1982). In a Different Voice: Psychological Theory and Women's Development. Cambridge, MA: Harvard University Press.

Gilligan, C., Ward, J.V., Taylor, J.M., and Bardige, B.(1988).Mapping the Moral Domain. Cambridge, Mass: Harvard University Press.

Goldberg, G.,and Kremen, E., (1990). The Feminization of Poverty: Only in America ? New York: Praeger.

Gomberg, E. (1995). Older Women and Alcohol Abuse. In P.Galanter(Ed.) Alcoholism and Women. New York: Plenum Press.

Goodman, L. A. (1991). The Prevalence of Abuse Among Homeless and Housed Poor Mothers. A Comparison Study. American Journal of Orthopsychiatry, 61, 489-500.

Gordon, L. (1988). "What Does Welfare Regulate?" Journal of Social Research, 55, 609-630.

Gordon, Linda (1994). Pitied But Not Entitled: Single Mothers and the History of Welfare. New York: The Free Press.

Grant, B. F., Harford, T.C., Dawson, D. A., Chou, P., Dufour, M., and Pickering, R. (1994). Prevalence of DSM-IV Alcohol Abuse and Dependence in the United States. Alcohol and Research World, 18, (3), 243-248..

Grinspoon, L. and Bakalar, J. B., (1976). Cocaine:A Drug and its Social Evolution. Basic Books, Inc. NY.

Hawkins, J.D. (1995). Controlling Crime Before it Happens: Risk Focused Prevention. National Institute of Justice Journal. Vol.229

Hayes, R. (1982). New York Times. December 15, 1982.

Helzer, J. E. and Pryzbeck, T.R.(1988). The Co-Occurance of Alcoholism With Other Psychiatric Disorders in the General Population and its Impact on Treatment. Journal of Studies on Alcohol, 49, 219-224.

Hinds, M.D.(1990). The Instincts of Parenthood Become Part of Crack's Toll.New York Times, 17,March.

Hoch, C., and Slayton, R. (1989). The New Homeless and Old: Community and Skid Row Hotel. Philadelphia : Temple Press.

Hollis, F. and Woods, M.(1981). Casework: A Psychosocial Approach 3rd. Edition. New York :Random House.

Hopper, K. (1990). Deviance and Dwelling Place: Notes on the Resettlement of Homeless Persons with Drug and Alcohol Problems. Contempory Drug Problems, 16, (3),391-414.

Hopper, K., Susser, E., and Conover, S.(1985). Economics of Makeshift: Deindustrialization and Homelessness in New York City. Journal of Urban Anthropology, 14, 183-236.

House Select Committee on Children, Youth and Families.(1990). Women and Children

Program Evaluation. Washington, D.C. :United States Congress.

HUD (1984) A Report to the Secretary on the Homeless and Emergency Shelters. United States Department of Housing and Urban Development, Washington, D.C. : Office of Policy Development and Research.

Hughes, P.H. Coletti, S.D., Neri, R.L., Urmann, C. F., Stahl, S., Sicilian, D.M., and Anthony, J.C. (1995) Retaining Cocaine -Abusing Women in a Therapeutic Community: The Effect of a Child Live-In Program. American Journal of Public Health, 85, (8), 1149-1152.

Humphries, D.(1999).Crack Moms. Columbus: Ohio State University Press.

Institute of Medicine.(1988). Homelessness, Health,and Human Needs. Washington DC: Institute of Medicine.

Jellinek, E.M. (1952). The Phases of Alcohol Addiction. Quarterly Journal of Studies on Alcohol, 13, 673-684.

Johnson, B. D. and Dunlap, E.(1996). The Crack Seller Lifestyle: Implications for Public Health Providers. National Development and Research Institutes. N.Y. N.Y. Presentation at the American Public Health Association Annual Conference. Nov.19,1996.

Jordan, J. V., Kaplan, A.G., Miller, J. B., Stiver, I. P., and Surrey, J., L. (1991) Women's Growth in Connection. New York: Guilford Press

Joseph, H. and Peone, D. (1997). The Homeless. In Lowinson, J.H., Ruiz, P., Millman, R.B.and J.G. Langrod Substance Abuse A Comprehensive Textbook 3rd. Ed. Baltimore: Williams and Wilkins.

Kaestner, E., Frank, B., Marel, R.and Schmeidler, J.(1986).Substance Abuse Among Females: Catching Up with the Males. Advances in Alcohol and Substance Abuse, 5, (3)29-49.

Koss, T. and Rosenthal, Robert.(1995). Interactional Synchrony, Positivity, and Patient Satisfaction in the Physician-Patient Relationship. Unpublished paper. Authors: Cambridge, MA: Harvard University, Department of Psychology.

Kingree, J.B.(1995). Understanding Gender Differences in Psychosocial Functioning and Treatment Retention. American Journal of Drug and Alcohol Abuse, 21, (2), 267-281.

Knickman, J. R. & Weitzman, B. (1889) A Study of Homeless Families in New York City: Risk Assessment Models and Strategies for Prevention Final Report Volume1. New York: Department of Public Administration, New York University.

Landry, M.J. (1997). Overview of Treatment Effectiveness. Substance Abuse and Mental Health Services Administration: U.S. Department of Health and Human Services. Rockville, MD.

Larkin, J.(1998). If You Want What We Have. Health Communications : Florida.

Laudet, A.L., Magura, S., Kumar,N., Barriers to Engaging Partners in Women's Substance Abuse Recovery. Paper Presented at the 124th Annual Meeting of the American Public Health Association. Nov.19, 1996. NY, NY: National Development and Research Institutes, Inc.

Leavitt R.L.(1981). Homeless Welfare Families A Search For Solutions: New Research on Multi-Problem Families, Community Council of Greater New York 225 Park Ave. New York,N.Y.

Lender, M.E. (1985). A Special Stigma: Women and Alcoholism in the Late 19th & 20th Centuries. In D. Strug, S. Priyadarsini, S., and M. Hyman. Eds. Alcohol Interventions Historical and Sociocultural Approaches. New York: Haworth Press.

Lettieri, D. (1980). A Guide To the Volume. In Letteiri et. al. NIDA Research Monograph 30. MD:Rockville :National Institute of Drug Addiction.

Levin, J.D.(1991). Treatment of Alcoholism and Other Addictions: A Self-Psychology Approach. New Jersey: Aronson.

Levinson, Valerie R. (1985). The Compatibility of The Disease Concept With A Psycho-dynamic Approach in the Treatment of Alcoholism. Journal of Alcoholism Treatment Quarterly, 2, (1),7-24.

Lewis, R.A., Haller, D.L., Branch, D., and Ingersoll, K. S. (1996). Retention Issues Involving Drug-Abusing Women in Treatment Research. In Raherdt, R. Treatment for Drug Exposed Women and their Children: Advances in Research Methodology. Research Monagraph Series #165. Rockville MD.: National Institute on Drug Abuse.

Lifton, Robert, J.(1972). On Psycho-history. In Psychoanalysis and Contemporary Science. Edited by Robert H. Holtand E. Peterfreund. New York :Macmillan.

Lindesmith, A.R.(1980). A General Theory of Addiction to Opiate Type Drugs. In D.J. Lettieri, M.Sayers, and H.W. Pearson (Eds.) Theories on Drug Abuse,Selected Contemporary Perspectives Monagraph 30. Rockville MD.:National Institute on Drug Abuse.

Loeber, R., Wung, P., Keenan,K., Giroux, B.,Stouthamer-Loeber, M., Van Kammen, W. B. & Farrington, D.P. (1991). Initiation, Escalation, and Resistance in Juvenile Offending and their Correlates. Journal of Criminal Law and Criminology, 82, (1).

Lofland, J and Lofland L.(1984). Analyzing Social Settings Belmont, California: Wadsworth Publishing.

Lowinson, J.H.(1981). Methadone Maintenance in Perspective. In J.H. Lowinson & P. Ruiz (Eds.) Substance Abuse Clinical Problems and Perspectives. Baltimore Maryland :Williams and Wilkens.

Lowinson, Joyce H., Ruiz, Pedro, Millman,Robert, and Langrod, John,G. (1997) Substance Abuse A Comprehensive Textbook Third Edition. Baltimore, MD: Williams and Wilkens, A Waverly Company.

Lugones,M.C., and Spelman, E.V.(1986). Have We Got a Theory for You! Feminist Theory, Cultural Imperialism and the Demand for The Woman's Voice. In M. Pearsall, Ed. Women and Values Readings in Recent Feminist Philosophy. Belmont, California: Wadsworth Publishing Co.

Mallucio, Anthony (1981). Promoting Competence in Clients. New York: Free Press.

Mass, H.S. (1986).From Crib To Crypt: Social Development and Responsive Environments As Professional Focus. New Brunswick. N.J.: Rutgers University Press.

Massing, M.(1998). The Fix. N.Y; Simon and Schuster Publishing.

McChesney, K.Y. (1992). Absence of a Family Safety Net for Homeless Families. Journal of Sociology and Social Welfare, 19, (4), 55-72.

McChesney, K.Y. (1995). A Review of the Empirical Literature on Contemporary Urban Homeless Families. Journal of Social Service Review, 37, 429-460.

McLellan, A.T., Grissom, G.R., Brill, P., Durell, J., Metzger, D.S., O'Brien, C.P. (1993). Private Substance Abuse Treatments: Are Some Programs More Effective Than Others? Journal of Substance Abuse Treatment, 10, 243-254.

McLellan, A.T., Metzger, D.S., Alterman, A. I., and O'Brien, C.P.(1994). Is Addiction Treatment Worth It? Public Health Expectation, Policy -Based Comparisons. Unpublished article from the Penn-VA Center for Studies of Addiction and The Treatment Research Institute. Philadelphia , Pennsylvania.

McLellan, A.T., Cacciola, J., Kushner, H., Peters, F., Smith, I., and Pettinati, H. (1992). The Fifth Edition Of The Addiction Severity Index. Journal of Substance Abuse Treatment, 9, 199-213.

Means, L.B., Small, M., Capone, D.M., Capone, T.J., Condren, R., Peterson M., and

Hayward, B. (1989). Client Demographics in Outpatient Cocaine Treatment. International Journal of Addictions, 24, 765-783.

Miles, M.B., & Huberman, A.M. (1994) An Expanded Sourcebook Qualitative Data Analysis 2nd. Edition. Thousand Oakes, California :Sage Publications.

Miller, B.A., Downs, W.R.,Gondoli, D.M., and Keil, A. (1987). The Role of Childhood Sexual Abuse in the Development of Alcoholism in Women. Journal of Violence and Victims, 2, (3), 157-172.

Miller, J.B.(1987). Toward a New Psychology of Women 2nd. Edition. Boston: Beacon Press.

Miller, D. (1991). Are We Keeping Up With Oprah ? A Treatment and Training Model for Addictions and Interpersonal Violence. In C.Bepko (ED.) Feminism and Addiction, New York :Haworth Press.

Miller, B.A., Downs, W. R. and Testa, M. (1993). Interrelationships Between Victimization Experiences and Women's Alcohol Use. Journal of Studies on Alcohol, Supplement 11,109-117.

Mintzberg, H.(1983) An Emerging Strategy of Direct Research. In John Van Maanan (Ed.) Qualitative Research Newbury Park California: Sage Publishing.

Miranne, Kristine, B.(1998). "Income Packaging as a Survival Strategy for Welfare Mothers." Affilia, 12, (2), 211-231.

Moffett, A.D., Bruce, J.D., and Horvitz. (1983). New Ways of Treating Addicts. In Francis J. Turner Differential Diagnosis and Treatment in Social Work Third Edition. New York: The Free Press.

Mondanaro, J., Wedenoja, M., Denson-Gerber, J., Elahi, J.Mason, M., & Redmond, A. (1982). Sexuality and fear of intimacy as barriers to recovery for drug dependant women. In B.Reed, G. Bescober, & J. Mondanaro (Eds.), Treatment Services for Dependant Women. Rockville, MD: National Institute on Drug Abuse.

Morgan, W.H. (1981). Drugs in America, A Social History, 1800-1940. New York: Syracuse University Press.

Morgan, J. and Zimmer, L. , (1997). The Social Pharmacology of Smokable Cocaine: Not all It's Cracked Up To Be. In Crack in America: Demon Drugs and Social Justice, Edited by C. Reinarman and H.Levine. Berkeley: University of California Press.

Murphy, S.and Rosenbaum, M. (1999). Pregnant Women on Drugs: Combating Stereotypes

and Stigma. New Jersey:Rutgers University Press.

Murphy, J.M., Jellinek, M., Quinn, D., Smith, G., Poitrast, F.G., and Goshko, M. (1991). Substance Abuse and Serious Child Maltreatment : Prevalence, Risk, and Outcome in a Court Sample. Journal of Child Abuse and Neglect, 15, 197-211.

Musto, David,F.(1997). Historical Perspectives. In J. H. Lowinson, P. Ruiz, R. B. Millman and J. G. Langford. Substance Abuse A Comprehensive Textbook 3rd. Ed. New York:Williams and Wilkins.

National Institute of Alcoholism and Alcohol Abuse (NIAAA). (1988). Women and Facts. United States Department of Health and Human Services. Rockville:MD: National Institute on Alcohol and Alcohol Abuse.

National Center on Addiction and Substance Abuse(1996). America and Substance Abuse. New York: Columbia University New York.

National Institute of Alcoholism and Alcohol Abuse (NIAA) (1990).Alcohol and Women: Alcohol Alert. United States Department of Health and Human Services. Rockville: MD: National Institute on Alcohol and Alcohol Abuse.

National Association Social Workers (NASW)(1993). NASW Code of Ethics. Washington, D.C.

Nelson-Zlupko, N., Kauffman,K.,and Dore, M.M.(1995). Gender Differences in Drug Addiction and Treatment: Implications for Social Work Intervention with Substance Abusing Women. Journal of Social Work, 40, (1), 45-54.

Nichols, M. (1985). Theoretical Concerns in the Clinical Treatment of Substance-Abusing Women: A Feminist Analysis. Alcoholism Treatment Quarterly, 2, (1) 79-90.

North, C.S., and Smith, E. M. (1994). Comparison of White and Nonwhite Homeless Men and Women. Journal of Social Work, 39, (6) 639-648.

Nunez, DaCosta, R.(1996). The New Poverty: Homeless Families in America. New York: Insight Books.

Orwin, R.G., Goldman, H.H., Sonnefeld, L.J., Smith, N.G., Ridgely, M.S., Mogren, R.G., O'Neill, E., Lucchese, J., Sherman, A., and O'Connell, M.E.(1992). Executive Summary: Community Demonstration Grant Projects for Alcohol and Drug Abuse Treatment of Homeless Individuals. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism.

Orwin, R. G., Goldman, H.H., Sonnefeld, L.J., Smith, N.G., Ridgley, M.S.,Mogren, R.G.,

O'Neill,E, and Sherman, A. (1994). Alcohol and Drug Abuse Treatment of Homeless Persons : Results from the NIAAA Community Demonstration Program. Journal of Health Care for the Poor and Underserved, 5, (4), 326-352.

Padgett, D.K. (1998). Does The Glove Really Fit? Qualitative Research and Clinical Social Work Practice. Journal of Social Work, 43, (4),373-381.

Paltrow, L.M. (1992). Criminal Prosecutions Against Pregnant Women. National Update and Overview. Reproductive Freedom Project American Civil Liberties Union Foundation.

Papchriston, J. (1976). Women Together: A History of the Womens' Movement in the United States. New York: Alfred A. Knopf.

Patton, M.Q.(1990) Qualitative Evaluation and Research Methods 2nd Edition. Newbury Park: Sage Publications.

Payne, M.(1991). Modern Social Work Theory: A Critical Introduction. Chicago: Lyceum Press.

Ralston, M.L. (1996). "Nobody Wants to Hear Our Truth: Homeless Women and Theories of the Welfare State. Westport, Connecticut: Greenwood Press.

Reed, Beth, Glover. (1985). Drug Misuse and Dependency in Women: The Meaning and Implications of Being Considered a Special Population or Minority Group. The International Journal of the Addictions, 21, (1) 13-61.

Reed, B. G. (1981). Intervention Strategies for Drug Dependant Women: An Introduction. In G. M. Beschner, B. G. Reed, and J. Mondanaro (Eds.) Treatment Services For Drug Dependant Women Vol.1. Rockville, MD: National Institute on Drug Abuse.

Reed, B. G. (1985). Drug Misuse and Dependency in Women: The Meaning and Implications of Being Considered a Special Population or Minority Group. International Journal of the Addictions, 20.

Reinarman, C.and Levine, H. G. (1989). Crack in Context: Politics and Media in Making of a Drug Scare. Contemporary Drug Problems, 16, 535-577.

Ridlen, S.(1997). The Effectiveness of Comprehensive Substance Abuse Treatment for Poor Urban Women. Unpublished Paper.

Roberts, A. C. and Nishimoto, R.H.(1996). Predicting Treatment Retention of Women Dependent on Cocaine. American Journal of Drug and Alcohol Abuse, 22, (3), 313-333.

Robertson, Majorie, J.(1991). The Homeless Women With Children The Role of Alcohol

and Drug Abuse. The American Psychologist, 46, (11), 1198-1204.

Rocherfort, D.A.(1986). American Social Welfare Policy. Colorado: Westview Press.

Rog. D.J., Holupka, C.S., and Mc-Combs-Thornton, K. L. (1995). Implementation of The Homeless Families Program: Service Models and Preliminary Outcome. American Journal of Orthopsychiatry, 65, (4), 502-513.

Root, M. (1989). Treatment Failure: The Role of Victimization in Women's Addictive Behavior. American Journal of Orthopsychiatry, 59, (4),542-549.

Rosenbaum, M. (1997). Women: Research and Policy. In J. H. Lowinson, P. Ruiz, R. B. Millman and J. G. Langford. Substance Abuse A Comprehensive Textbook 3rd. Ed. New York:Williams and Wilkins.

Rosenthal, Robert (1986) Nonverbal Communication in the Clinical Context. University Press: Pennsylvania State.

Ross, H.E., Glasser, F.B. and Stiansy, S. (1988). Sex Differences in the Prevalence of Psychiatric Disorder in Patients with Alcohol and Drug Problems. British Journal of Addictions, 83, (1), 1179-1192.

Rossi, P. H. 1994. Troubling Families: Family Homelessness in America. American Behavioral Scientist, 37, 342-395.

Roth, P. (1991). Alcohol and Drugs are Women's Volume I. New Jersey: Scarecrow Press.

Saladin, M.E., Brady, K.T., Dansky, B.S., and Kilpatrick, D.G. (1995). Understanding Commobidity between PTSD and Substance Use Disorder: Two Preliminary Investigations. Addictive Behaviors,. 20, (5).

Saleeby, D.(1986). A Social Psychological Perspective on Addictions: Themes and Disharmonies. In T. Watts Ed. Social Thought of Alcoholism. Florida: Kraiger Publishers.

Sandmaier, M. (1980).The Invisible Alcoholics :Women and Alcohol Abuse in America. Tab Books, Blue Ridge Summit, PA.

Schlosser, E. (1997). More Refer Madness. Atlantic Monthly, April, 279, (4), 90-102.

Schmidt, G., Klee, L., and Ames, G. (1990). Review and Analysis of Literature on Indicators of Women's Problems. British Journal of Addiction, 85, (2), 179-192.

Schumacher, J.E., Siegal, S.H., Socol, C.J., Harless, S., and Freeman, K. (1996). Making Evaluation Work in Sustance Abuse Treatment Work for Women and Children: Olivia's

House. Journal of Psychoactive Drugs, 28,(1), 73-83.

Shane, P.,Ridgley, M.S., Sherman, A., O'Neill, Goldman,H., Wittman, F., Smith, N.G. (1992). Volume 11: Case Studies on Nine Community Demonstration Grants. Rockville, MD. National Institute on Alcohol Abuse and Alcoholism.

Shinn, Marybeth, Knickman, J. R., and Weitzman, Beth, C.(1991). Social Relationships and Vulnerability to Becoming Homeless Poor Families. American Psychologist, 46, (11), 1180-1188.

Shinn, M., Weitzman, B., Stojanovic, D.,Knickman, J.R., Jimenez, L., Duchon, L., James, S., and Krantz, D. H. (1998). American Journal of Public Health, 88, (11), 1651-1657.

Sidel,R. (1996) Keeping Women and Children Last. New York: Penguin Books.

Siegel, L.(1991). The Criminalization of Pregnant and Child Rearing Users: An Example of The American Harm Maximization Program. Paper Presented at the First International Conference on the Reduction of Drug related Harm. April.

Siguel,E.N.and Spillane, W.H.(1978). The Effects of Prior Treatment on Treatment Success. The International Journal of the Addictions, 13, (5), 797-805.

Simpson, D. D., (1984). National Treatment System Evaluation based on the Drug Abuse Reporting Program (DARP) Follow -up Research. In F. M., and J.P. Ludford Eds. Drug Abuse Treatment Evaluation: Strategies, Progress and Prospects. NIDA Research Monograph 51. National Institute on Drug Abuse. Rockville, Maryland.(ADM)84-1329.

Smith, E.M., North, C.S., Heaton, T.M. (1993) A Substance Abuse Recovery Program for Homeless Women Mothers with Children: St. Louis. Alcoholism Treatment Quarterly, 10. (3/4), 91-100.

Smith, Michael. (1990). Program Evaluation in the Human Services. New York:Springer Publishing.

Smith, E.M., North, C.S. & Fox, L.W.(1995). Eighteen-Month Follow-Up Data on a Treatment Program for Substance Abusing Mothers. Journal of Addictive Diseases, 14, (4),57-72.

Smith, M. and Fabricant, M. (1992). An Integrated Quantitative-Qualitative Approach to the Evaluation of a Supported Housing Program for the Mentally Ill. Unpublished Report. Hunter College School of Social Work: N.Y. N.Y.

Smyth, N.J. and Miller, B.A. (1997)Parenting Issues For Substance-Abusing Women. In S.L.A. Straussner and E.Zelvin (Eds.). Gender and Addictions: Men and Women In

Treatment. Jason Aronson Inc.:N.J.

Snyder, I. (1980). Introduction. In D.J. Lettieri, M. Sayers and H.W. Pearson. Theories on Drug Abuse selected Contemporary Perspectives. NIDA Research Monograph 30. United States Department of Health and Human Services. National Institute on Drug Abuse. MD: Rockville.

Spect, H. and Courtney, M. (1994). Unfaithful Angels: How Social Work has Abandoned its Mission. New York: Free Press.

Stahler, G.J.(1995). Editorial: Social Interventions for Homeless Substance Abusers: Evaluating Treatment Outcomes. Journal of Addictive Diseases, 14, (4) xv-xxvi.

Stark, M.J. (1992). Dropping Out of Substance Abuse Treatment: A Clinically Oriented Review Journal of Clinical Psychology Review, 12, (9), 93-116.

Stefl, M. (1987) The New Homeless. In The Homeless in Contemporary Society. Eds. Bingham , R.D, Green, R.and White, S.B.New York: Sage Publications.

Sterk-Elifson, C.(1995). Determining Drug Use Patterns Among Women: The Value of Qualitative Research Methods. In E.Y. Lambert, R.S. Ashery, & R.H. Needle. Qualitative Methods in Drug Abuse and HIV Research. NIDA Research Monograph 157. National Institute on Drug Abuse, Rockville, MD.

Stevens, S. Arbiter, N., and Glider, P.(1989). Women Residents: Expanding Their Role to Increase Treatment Effectiveness in Substance Abuse Programs. International Journal of Addiction, 24, 425-434.

Stevens, S.J., Chong, J., Erickson, J.R. (1997). Homelessness and Substance Abuse: The efficacy of Modified Residential and Nonresidential Therapeutic Community Models. In G. DeLeon Community as Method. New York: Free Press.

Straussner, S.L.A. and Zelvin, E. (1997) Gender and Addictions: Men and Women in Treatment. Northvale, NJ:Jason Aronson.

Straussner, S.L.A. (1985). Alcoholism in Women: Current Knowledge and Implications for Treatment. In D. Cook, S. Straussner,S.L.A. and C. Fewell.Eds. Psychosocial Issues in the Treatment of Alcoholism. New York: Haworth..

Strozier, Charles (1992). Lifton's Method Journal of the Psychohistory Review, 20, (2),131-144.

Swarns, R.L. (1999). Mayor Relents on Plan To End Methadone Use. New York Times. January, 16.

Synder, M.(1980). Forward. In D. J. Lettieri, Mollie Sayers, and Helen Wallenstein Pearson (Eds.).Theories on Drug Abuse Selected Contemporary Perspectives. Research Monograph Series #30. Rockville MD.: National Institute on Drug Abuse.

Taha-Cisse, M.(1991) African-American Women and Substance Abuse Issues. In P.Roth (Ed.) Alcohol and Drugs are Women's Issues. New Jersey: Scarecrow Press.

Tamerin, J. (1985). The Psychotherapy of Alcoholic Women. In Zimberg, S., Wallace, J.,and Blume, S.B.Practical Approaches to Alcoholism Psychotherapy 2nd. Edition. New York: Plenum Press.

Terry, C.E., Pellen, M.,(1928) The Opium Problem. The Committee on Drug Addiction in Collaboration with the Bureau of Social Hygiene. NY.

Tripoldi, T., Fellini, P. Epstein, I, and Lind, I.(1977). Social Workers at Work. Illinois: F. E. Publishers

Turnbull, J.E.and Gomberg, E.S.C. (1988). Impact of Depressive Symptomology on Alcohol Problems in Women. Journal of Alcoholism: Clinical and Experimental Research, 12, 374-380.

Turnbull, J.E.and Gomberg, E.S.C. (1990). The structure of Depression in Alcoholic Women. Journal of Studies on Alcohol, 51, (2), 148-155.

U.S. Conference of Mayors. (1995). A Status Report on Hunger and Homelessness in American Cities: A 26 city survey. Washington, D.C.

Underhill, B.L. (1986). Issues Relevant To Aftercare Programs For Women. Alcohol Health and Research World, 11, (1),46-48.

Valliant, G.E.(1988). What Can Long Term Follow Up Teach Us about Relapse Prevention of Relapse in Addiction? British Journal of Addiction, 83, (10),1147-1158.

Van Ry, Merideth, 1993, Homeless Families- Causes , Effects, and Recommendations. New York: Garland Publishing.

Vannicelli, M. (1984). Barriers to Treatment of Alcoholic Women. Journal of Substance and AlcoholActions and Misuse, 5, (37),29-37.

Volpe, J. and Hamilton, G. (1983). How Women Recover: Experience and Research Observations. Alcohol Health and Research World, 7, (2),28-39.

Von Bertalanffy, L.(1981). A Systems View of Man. Boulder, Colorado: Westview Press.

Wallace, John (1978). Working with Preferred Defense Structure of the Recovering Alcoholic. In S. Zimberg, J. Wallace and S. Blume. Practical Approaches to Alcoholism Psychotherapy. New York: Plenum Press

Warren, K., Franklin, C. and Streeter C.L.(1998). New Directions in Systems Theory: Chaos and Complexity. Journal of Social Work, 43, (4) 357-372.

Watson, S. and Austerberry H.(1986). Housing and Homelessness: A Feminist Perspective. London:Routledge and Kegan.

Wegscheider, S.(1981). Another Chance: Hope and Help for the Recovering Alcoholic Family. Science and Behavioral Books: Palo Alto, California.

Weinberg, John (1973). Counseling Recovering Alcoholics. Journal of Social Work, 43, (4), 84-93.

Weinreb, L. F., and Bassuk, E. (1990). Substance Abuse: A Growing Problem among Homeless Families. Journal of Family and Community Health, 13 55-64.

Weinreb, L. F., & Rossi, P. H. (1995). The American Homeless Family Shelter System. Social Service Review, 69, 86-107.

Wesson, D. R., Carlin, A.S., Adams, K. and Beschner, G. (1978) Polydrug Abuse. Academic Press: New York.

Westermeyer, J. (1989) "Nontreatment Factors Affecting Treatment Outcome in Substance Abuse. American Journal of Drug and Alcohol Abuse, 15, (1),13-29.

Williams, M.T. and Roberts, C. S. (1991). Predicting Length of Stay in Long-Term Treatment for Chemically Dependant Females. The International Journal of Addictions, 26, (5),605-613.

Williams, J. H.(1987). Psychology of Women: Behavior in a Biosocial Context 3rd. Edition. New York: W.W. Norton.

Wilsnak R.. and Wilsnak, S.. (1992). Women, Work, and Alcohol: Failure of Simple Theories. Alcoholism: Clinical And Experimental Research, 16, (2), 172-179.

Wilsnak, S. (1995). Alcohol Use and Alcohol Problems in Women. In A.L. Stanton and S.J. Gallant Eds. The Psychology of Women's Health. American Psychological Association. Washington:DC.

Winfield, I., George, L.K., Swartz, M., and Blazer, D.G. (1990). Sexual Assault and Psychiatric Disorders Among A Community Sample on Women. American Journal of

Psychiatry, 147, 335-341.

Winick, C. (1974) A Sociological Theory of the Genesis of Drug Dependence. In Charles Winick Ed. Sociological Aspects of Drug Dependence. Ohio: CRC Press.

Winick, C. and Larson, M.J.(1997).Community Action Programs. In Lowinson, J.H., Ruiz,P., Millman, R.B. and Langrod, J.C.(Eds.) Substance Abuse A Comprehensive Textbook 3rd. Ed. Baltimore: Williams and Wilkins.

Winick C. and Evans J. T. (1997). A Therapeutic Community Program for Mothers and their Children. In Lowinson, J.H., Ruiz,P., Millman, R.B. and Langrod, J.C.(1997). Substance Abuse A Comprehensive Textbook 3rd. Ed. Baltimore: Williams and Wilkins:.

Winick, Charles. (1991). The Counselor in Drug Treatment. The International Journal of The Addictions, 25, (12A), 1479-1502.

Wobie, K., Eyler, F.D., Conlon,M., Clarke, L., and Behnke, M.(1997). Women and Children in Residential Treatment: Outcomes for Mothers and their Infants. Journal of Drug Issues, 27, (3).

Wood, D. Valdez, R.B., Hayashi, T., & Shen,A. (1990). Homeless and Housed Families in Los Angeles: A Study Comparing Demographic, Economic, and Family Function Characteristics. American Journal of Public Health, 80, 1049-1052.

Wood,D., Schlossman, S. Hayashi, T, & Valdez, R. B.(1989). Over The Brink: Homeless Families in Los Angeles. Sacremento, Ca.: Assembly Office of Research.

Wooley, S. and Kearney-Cooke, A. (1986) Intensive Treatment of Bulimia and Body Image Disturbance. In K. Brownell and J. Foreyt (Eds.) Physiology, Psychology, and the Treatment of Eating Disorders. New York: Basic Books.

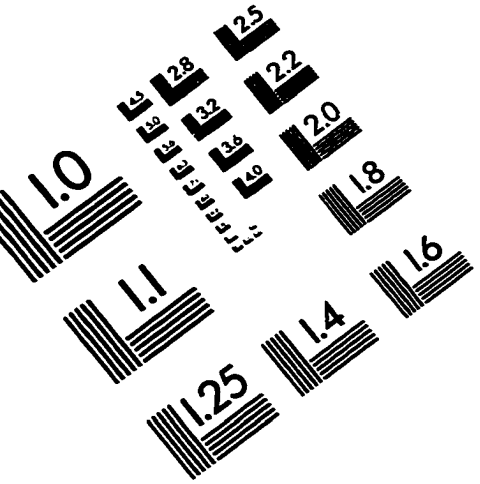
Worth, Dooley. (1991) American Women and Polydrug Abuse. In Alcohol and Drugs are Women's Issues. Ed. Paula Roth. New Jersey: Scarecrow Press.

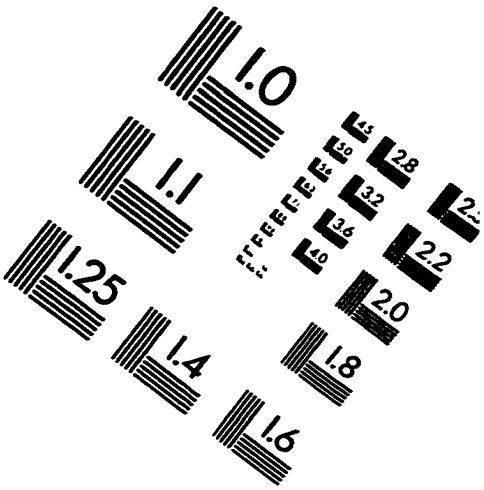
Wright, J.D. and Lam, J. (1987). Homelessness And The Low Income Housing Supply. Journal of Social Policy, 17, (4), 48-53.

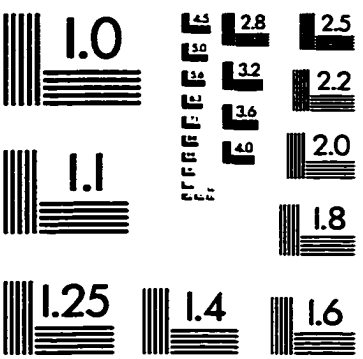
Zankowski, G.L. (1987). Responsive Programming: Meeting the Needs of Chemically Dependant Women. Alcoholism Treatment Quarterly, 4 (4) 53-66.

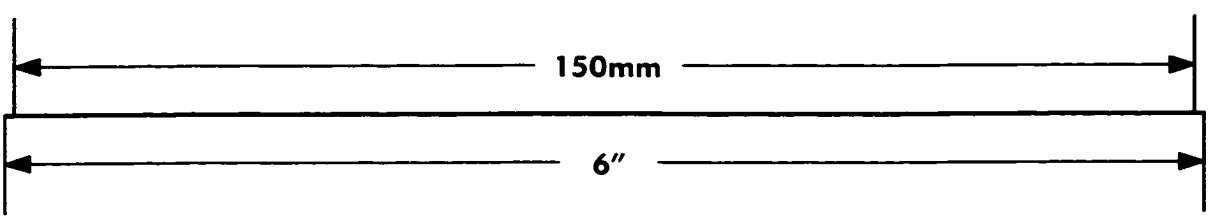
Zimmer, R., and Schretzman, M. (1990). Homeless Women with Children. In P. Roth Ed. Alcohol and Drugs are Women's Issues. New Jersey: Scarecrow Press.

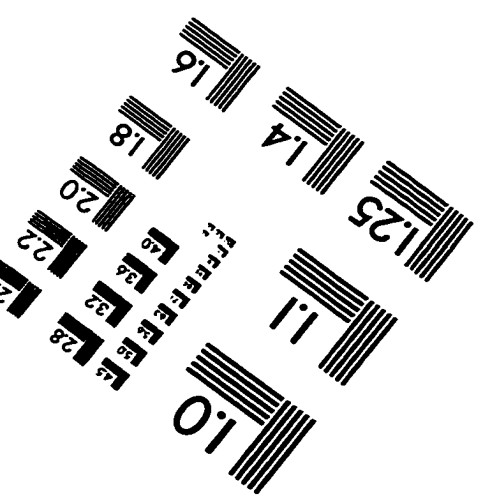
IMAGE EVALUATION TEST TARGET (QA-3)

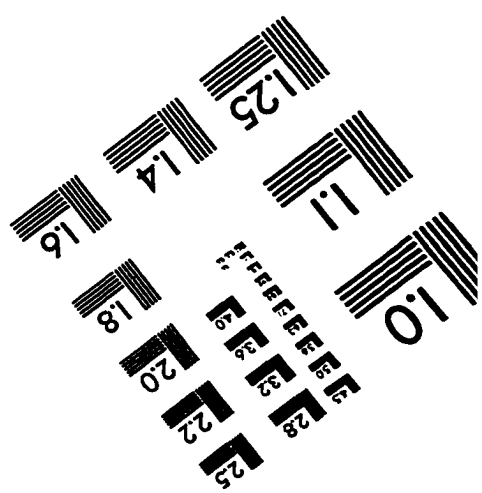












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